





# BRIEF

submitted to the

# ROYAL COMMISSION ON HEALTH SERVICES

by the

ONTARIO MEDICAL ASSOCIATION

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#### DEFINITIONS

Doctor: A doctor of medicine, unless otherwise designated.

Physician: A general term to include doctors of medicine in any

type of practice.

Para-medical

Workers: Those working closely with the medical profession in the

Para-medical care of patients, e.g., nurses, physiotherapists, Personnel: occupational therapists, technicians, dietitians.

Ancillary

Services: Services associated with physicians' services, e.g.,

nursing, physiotherapy, occupational therapy, pharmaceutical services, ambulance services.

Branch

Society: A component of the Ontario Medical Association, made

up of members on a territorial (usually county) basis.

There are 57 branch societies.

District: A group of branch societies within a geographic area.

There are 11 districts.

Board of

Directors: Members elected to administer the affairs of the

Association. Seventeen are elected by the districts,

one by the medical schools and five by Council.

Executive

Committee: The five elected officers of the Association; President,

Past-president, President-elect, Chairman of Council

and the Honorary Treasurer.

The Executive Committee has the authority of the Board

of Directors between meetings of the Board.

Council: A representative body of members. Council provides

direction with respect to Association policy about matters raised in reports from the Board of Directors, and the

committees of the Association.

Section: A group of at least twenty-five members with a common

interest, i.e., surgery, group practice, geriatrics, preventive medicine, etc., There are 25 sections.

Committee: A group of members appointed by the Board of Directors

to study and report on matters within the assigned terms of reference, e.g., education, economics. The number of committees varies from year to year. At present

there are 29.

Mediation

Committee A committee established at branch society, district or

Board of Directors level to consider written complaints

about such matters as fees charged by members.

VERBAL PRESENTATION AT ROYAL COMMISSION ON HEALTH
SERVICES HEARING, May 7, 1962, by Dr. P. Bruce-Lockhart,
President-elect (now President,) of the Ontario Medical Association

Mr. Chairman and Members of the Commission:

- The Ontario Medical Association, whom this delegation has the honour to represent, has 6,500 members. It thus constitutes about one-third of the total doctors in Canada, and looks after over 6,000,000 people.
- 2. The Commission and the Ontario Medical Association have a common interest, namely, the provision of competent health services to the people of Ontario. The Commission by reason of its terms of reference this Association through the dedication of the lives of its members to this work.
- In order to assist the Commission in a better understanding of the problems in Ontario, the O. M. A. has:
  - Studied all previous hearings, considered carefully the questions asked by the Commissioners, and noted how frequently the same questions have been asked of all doctors.
  - With the object of answering these questions, while at the same time presenting the views of the O. M. A. on what it deems to be the vital issues, it is proposed that our presentation will be in three parts.
- 4. Firstly, I will present a broad outline of the Ontario doctors' viewpoint, in an attempt to give the Commissioners an insight into the core of our thinking and to place our brief and arguments into perspective.
- Secondly, Dr. Glenn Sawyer will summarize and comment on the recommendations in the brief, so as to give clarity and point to our priorities.

- 6. Then this delegation would like to answer any further questions deemed relevant by the Commissioners although we believe that our presentation will have answered most of the questions asked heretofore by the Commissioners, and that they will have learned the viewpoint and policy of the O. M. A. on these vital issues.
- 7. This course of action will have the advantage of enabling the O. M. A. to make its uninterrupted presentation within the allotted time, and yet give the Commissioners the opportunity to indicate those areas on which they desire further information.
- 8. In order even to begin to understand doctors, one first has to appreciate that medical care in essence is the care of the sick individual, or the potentially sick, or the well who may become sick, but always the individual.
- 9. It is essential to understand that an individual is a human being who is unique and different from all other human beings different in his reaction to environment, in his reaction to illness, to drugs and to treatment, different in his reaction to management, and different in his reaction to other human beings which must include doctors.
- 10. These differences of reaction are drummed into medical students, because bitter experience has taught the profession that unless a constant unrelenting awareness is maintained in this regard, constant mistakes will occur. The necessity for this has convinced doctors that medical care must be personal if it is to be efficient and safe. Further, that it must be personal if it is to be effective in dealing with the patient in relationship to his environment.

- 11. To place these personal services in perspective, it should not be forgotten that home and office calls constitute the majority of all medical services rendered by doctors. The doctors providing personal services work long hours, and their whole life is one constant interruption. Yet few abandon it, and to understand why, one must understand doctors.
- 12. The answer is not that they are, or think themselves, supermennor even that they are just a strange breed, as some would have us believe. It is just that to date there has been an intense satisfaction in their work. This satisfaction is the result of the pleasure found in becoming involved with people, of being able to help them in their need and of caring about the results, not as cases in a slot, but as human beings.
- in debt. He is initially delighted and somewhat thankful to answer calls night and day. Then the financial problem improves, his youth and enthusiasm diminish, but he finds that he continues to accept these calls, these interruptions to his meals, his spare time, his family occasions, because by that time a call is not just another case, but young Johnny with his asthma, old Bill with another heart attack, or Mrs. Tessier with what sounds like an acute gall bladder. Herein, quite simply, lies the source of doctors' dedication and devotion to their calling.
- 14. This devotion to a patient's interests, this dedication to service, is a thing that only a very few lay people understand to any depth, beyond a superficial reaction typified by "that old doctor-patient relationship business." And yet if one does not understand this,

how can one possibly understand our complete conviction that anything that interferes with this dedication to the individual and the job satisfaction which produces it, will ultimately and quite inevitably produce a lowering of the quality of medical care. Can one buy, or compel, devotion? Obviously not.

- Now over the years, as spelled out in our brief, this dedication with its intense concern for the individual, has produced a complex of medical services in this province which we believe is second to none; which is not static but constantly changing; and has only one criterion, namely, does it meet the need of the patient?
- 16. Living in this way, the profession has always been, and of course is still, acutely aware of the problems of patients; problems medical, organizational and economic. We must be, it is part of the fabric of our lives. We are constantly searching for and finding answers, usually initially at the individual level, and then when they have stood the test of experience, these are generally adopted. Just as we test a new drug before its general adoption in order to minimize the chance of its doing harm as well as good, so experience has taught us to shun the quick solutions to organizational problems. Our brief emphasizes the steady progress being made in solving these problems by the evolutionary process, and we are confident that given time the remainder will be solved without disturbing the essential relationship and atmosphere between doctor and patient.
- 17. However, public awareness of some of these problems the indigent, the low income group and the uninsurables, the cost of facilities, under-doctored areas, to mention a few, has produced the urge, very

natural in the inexperienced, to correct these problems immediately.

Quick action in this day and age, with memories of recent war time experience, brings thoughts of a master plan, central control, and government assistance with financing.

- 18. Political parties are, of course, not unaware that benefits to the public obtain votes. A further factor to be taken into consideration is that if governments provide monies then they feel responsible to control its expenditure.
- 19. Thus the stage is set for the present conflict of ideas between governments and the medical profession.
- 20. In our brief we have stressed the theme evolution, not revolution, by stating what we have done, why, why it is good, how we are tackling the problems that remain, the needs that exist and how solutions can be evolved to meet them.
- 21. To keep this clear, we have not stated directly where we stand in this conflict of ideas, and we would be failing in our duty if we did not now take this opportunity to make quite clear where the medical profession in Ontario does stand in this regard.
- 22. First in regard to availability of medical care, we would state our opinion that in Ontario medical care is at present available to all citizens having only regard to geographic circumstances.
- 23. Secondly, our profession is convinced that very few people outside the profession understand the danger of well meaning planners seizing on a few problems in this very complex field, and producing solutions to them only to create unwittingly and quite unintentionally, a dozen new ones.

- 24. Thirdly, we are frankly afraid of any plan, or plans, with total or major government financing because history has taught us
  - a) that then the monies for medical care have to compete at the treasury level with the other needs of society, which means that political expediency dictates the allocation of money and not individual medical needs.
  - that costs rise way beyond estimates and the easiest way to control costs is to limit facilities and services.
  - c) the loss of individual patient responsibility for his own care is a factor in increased costs, and further subtly alters his attitude towards his doctor. When a patient demands care instead of calling with a problem for help, then the job satisfaction of the doctor is gone.
- 25. In addition to these fears, we are flatly opposed to government ever being the sole purchaser of medical services, because quite simply we would consider this conscription. Would this situation not be vicious if the only way a man can change his employer is by leaving the country? It seems to us that it would be a new and unique position if this occurred and was acceptable, and would inevitably lead to the question of "who is next?"
- 26. In theory, a government could own an insurance plan, solve some of the economic problems of the populace and not interfere with the individual patient and his doctor. Here we would like to be careful of words. An insurance plan for medical care is a concept of people buying insurance to spread the risk. Such plans are at present available, and the problem of enabling everyone to buy insurance is discussed in our brief. However, when one talks of

government insurance we believe this implies control beyond this insurance principle, because experience has taught us this.

Government insurance to us means just a government run medical plan under another name.

- We are convinced that a government run plan of medical care will mean central control; that central control produces a mediocrity of care because it is geared to the masses and not to the individual and his needs. Further, because it works on an averaging principle.

  Frankly we do not believe it possible to deal in norms and averages and retain complete individual patient consideration and attention.
- Also, we are completely opposed to compulsion direct or indirect
  because one cannot have compulsion and choice. We believe that
  choice of doctor, choice of type of service, choice of type of
  prepayment mechanisms is productive of flexible selective progress
  geared to individual needs.
- 29. We are certain that in the long run government interference in the practice of medicine, directly or indirectly through financial control, however well intended, will affect the dedication of the doctors by diminishing their satisfaction in giving service. It will also increase the problem of finding adequate personnel. What serious student contemplating a medical career would not prefer infinitely the opportunities for freedom in service in the state to the south of us rather than a bureaucracy at home.
- 30. Mr. Chairman, we have explained as best we might our fundamental concept of medical care, we have stated our views on government intervention in medical care. We would like to complete the picture by

stating that we believe that good medical care is the concern of all of us. That to produce it the profession needs co-operation from government and voluntary agencies, that we each have our place in this field and that we have views on the proper role of government which we would like to emphasize very briefly. They are the result of a study by one of our committees and were approved by the profession in the Council of the Association three years ago.

#### 31. The report reads:

"Our concept of the responsibility of government with regard to the health of the public is to ensure, in co-operation with, and on the advice of, the medical profession as a whole, that a high standard of medical care is available to everyone. With these thoughts in mind, we should consider the proper role of government in the field of medicine.

Central government has three advantages over any other section of the community, namely:

- i) Central view and authority.
- ii) The power to legislate.
- iii) The provincial treasury.

It seems logical that these aspects of medicine which fundamentally require any of these things are properly the concern of government.

#### A. Aspects of medicine requiring essential province-wide view:

- Sanitation, preventive medicine, and venereal and infectious disease control.
- ii) Civil defence and disaster planning.
- iii) The education of the public in health and hygiene matters.

- B. Aspects requiring the authority of legislation:
  - Legislative jurisdiction with respect to the licensing of doctors to practice medicine.
  - ii) Legislative jurisdiction over hospitals.
  - iii) Legislative standards for food and its handling, housing, drugs, and safety precautions in homes and factories, institutions, etc.

#### C. Aspects requiring assistance from the provincial treasury:

- i) In situations where the individual is incapable of providing for himself because of
  - a) indigency,
  - b) chronic or permanent mental or physical disability.
- ii) In situations where a particular community would otherwise shoulder the financial load for a project beneficial to the whole province
  - a) medical education,
  - b) medical research,
  - c) facilities which are expensive or located in small number of centres, e.g. radiotherapy by Cobalt Bomb, etc.
  - d) subsidizing hospital building and operating costs."

VERBAL PRESENTATION AT ROYAL COMMISSION ON HEALTH SERVICES HEARING, May 7, 1962, by Dr. Glenn Sawyer, General Secretary, Ontario Medical Association

#### Mr. Chairman and Members of the Commission:

- We would ask that the summary and recommendations as contained
  in our brief be written into this record. It is my purpose to develop
  briefly the reasons for the recommendations in order that you may
  have a better understanding of them.
- You will appreciate that many of the problems confronting you as Commissioners have formed the basis of continuing study by committees and sections of our Association. The appendices, to which we would direct your attention, are the result of such studies over the past few years. The suggestions contained in them relate to improvement in various aspects of health services and are worthy of your consideration.
- 3. I would like to discuss five broad areas of recommendations. At the conclusion of my remarks I would be happy to direct any questions you might have to members of our Association who are here to assist you.

#### 4. PERSONNEL

The first area is personnel. There is an old saying that an army marches on its stomach. Health services march on personnel and it is as difficult to develop adequate health services without personnel as it is to make the proverbial bricks without straw.

- 5. From reading briefs presented to you previously, it is apparent that the shortage of personnel is not unique in our province. Each area has reasons why this is so. In Ontario we have a rapidly expanding population demanding more and more health services.
  Added to that has been rapid advances in medical science making it possible to give a wider area of increasingly complex services.
- 6. In contrast to what is happening in industry, where automation is creating a lessening demand for personnel, the complexity of health services requires a constant increase both in the number and in their qualification. The difference, of course, is because health services are personal services, whether they are rendered by a physician, a nurse, or a physiotherapist.
- 7. The physician is dependent upon the other members of the health team. If there is a shortage of personnel in one category, it can affect the quantity and quality of available health services. We find this, for example, in our hospitals, where wards are sometimes closed because of the shortages of nurses.
- 8. The branch societies and sections of our Association have indicated in their submissions shortages in many categories of health service personnel.
- 9. The first question which arises is the number of students available who have the qualifications required for acceptance for training in the health field. An examination of the students who entered high school in Ontario in 1955 reveals that at the end of 1960 only 4,718 (7.6%) had the necessary qualifications. The various health professions had to compete with all other groups requiring these qualifications from this small percentage.

- 10. We are aware that those interested in education are concerned about this situation. While commending them for their concern, we have recommended intensified efforts to delineate and correct the factors responsible.
- 11. With the relatively small number available, it becomes a matter of ability to attract students in the health field who have the qualities of heart and mind required to render dedicated personal health services. It is our opinion that while remuneration is important, the test in the final analysis will be ability to render professional services in a manner which will produce the satisfaction on which professional services are dependent. A survey of 597 Grade XIII students, attached to this brief as an appendix, would substantiate that view.
- 12. Having trained health workers, the next problem is to keep them.

  The Section on Salaried Physicians has drawn to our attention the situation in the public medical services, staffed by salaried physicians, of our province. Here the loss of physicians through emigration causes concern about the quality of these services. The loss is attributed to the low salaries paid in Ontario as compared to those available in private practice and also in salaried positions outside the public service. It is pointed out that both the salaries available and their relationship to earning in private practice are factors causing emigration to the United States.
- 13. There is a loss of para-medical personnel through emigration and this is to be regretted. A more serious loss, however, is from marriage. By tradition, the vast majority of workers in the paramedical field have been female. Attempts to attract men into this

work have not been very successful to date. This is difficult to understand from a physiological point of view. The answer, again, has been given as inadequate salaries both during and after training, so that a man with family responsibilities seeks other employment.

14. We have indicated in our brief the need for continued study of the financial support required of trainees in all areas of the health field.
Our recommendations in this area are:

THAT the study now being made by our educationalists be
intensified to determine and correct the factors responsible for
the small percentage of students graduating from Grade XIII with
the qualifications required for entrance into training in the health
field.

THAT the financial requirements of students in training be reviewed.

THAT salary levels be made such as to retain our health workers and attract more male workers into the para-medical work, and THAT provision be made for necessary staff and facilities to meet future needs for personnel in the health field.

#### 15. FACILITIES

The mention of facilities brings us to the next area. We did not expand on the need for facilities for the training of physicians and all other health workers because the needs in this area will undoubtedly be brought forward by the universities and others.

We do want to say something about the facilities required for the care and treatment of the sick. The first of these is hospitals; acute, convalescent, and chronic. While the picture generally in the province has improved, there are areas where there has been a particularly rapid growth of population where the situation is very poor indeed. Metropolitan Toronto is a good example. Here there are 3.9 beds per thousand as compared to the provincial average of 5. Here, too, the municipal government has refused to participate in the costs of hospital construction.

- 17. A review of contributions for hospital construction shows that the federal and provincial governments combined have contributed one-half as much as is left as the responsibility of the local municipality and the citizens. Hence, when the municipal government refuses to participate, the matter of hospital construction places an unbearable burden on the backs of even the most willing citizens.
- 18. We have suggested that the contribution made by the two senior levels of government be reviewed and a formula worked out with the municipalities. Then when need for a hospital has been determined by the Ontario Hospital Services Commission in co-operation with the Ontario Hospital Association and our Association, the funds would be available. This would give the O. H. S. C. the fiscal autonomy in this area which we feel is required to produce adequate facilities.

  As one man remarked:

"Children are provided a seat in school and a gymnasium in school to play in but if they get sick there may not be a hospital bed available to lie in."

19. The requirement for hospital beds can be lessened if there is sufficient domiciliary accommodation, i.e., nursing homes and homes for the aged, where those requiring care, but not continuing medical and nursing care, may be transferred. While the Department of Public Welfare is making determined efforts to meet the need in this area, it would seem reasonable that there should be the closest liaison between the O. H. S. C. which is responsible for hospitals and the Department of Public Welfare, responsible for domiciliary accommodation.

- 20. There are special needs for facilities. One of these is for the treatment of mental illness as outlined in the submission of the Section on Psychiatry. The requirement is for both small psychiatric hospitals beside general hospitals, and also psychiatric units within general hospitals.
- 21. A second conference on rehabilitation recently emphasized again the need for community participation in the provision of workshop facilities and sheltered employment.
- 22. Similar recommendations have been made by our Committee on Child Welfare as a result of a one-year survey of the needs of the handicapped children.
- 23. In all of these areas, facilities for research are a continuing requirement.
- 24. In the area of facilities, then, we would direct your attention to the need for:
  - Facilities for training health workers.
  - Hospital facilities acute, convalescent, chronic.
  - Domiciliary accommodation nursing homes, homes for the aged. Special facilities for:
  - The treatment of mental illness; for rehabilitation; the care of the handicapped children, and research.

# 25. <u>UTILIZATION OF PERSONNEL AND FACILITIES IN THE</u> IMPROVEMENT OF HEALTH SERVICES

There are areas as indicated in the brief, where continuing study is required in the utilization of personnel and facilities.

- We have stated the opinion of the Association that the needs of university hospital teaching units must be met in order to assure a high quality of medical graduate. These units must be under the control of the university staff. Other than that, it is our opinion that hospital beds coming under the Public Hospitals Act should be available to doctors of the community within their competence to use them.
- 27. In speaking of hospitals, we have expressed our concern lest the autonomy of hospitals be lost because of having only one purchaser of basic hospital services.
- 28. The continuing work of our committees and sections has demonstrated areas for improvement in the use of personnel and facilities.
- 29. There is need for a change in the management of mental illness to bring it into line with the management of physical illness. This will require more community interest in hospital construction and management and more participation in patient care by the doctors of the community.
- 30. In rehabilitation, there is need for a provincial co-ordinator to integrate the interest of government departments in this area.

- 31. Handicapped children should be registered and our Association is considering undertaking this task. There is need for a council composed of representatives of health, education and welfare for the purpose of co-ordinating agencies and programs and integrating services.
- 32. Public health measures requiring attention are fluoridation of communal water supplies, the correction of air and water pollution and the establishment of public health units in areas of the province now without them.
- 33. The benefits of occupational health services to the working population in maintaining and improving health are worthy of mention.
- 34. Consideration of medical aspects of traffic accidents has focused attention on the need for improved ambulance services; the need for driver education; the value of seat belts; and the problems created by the "drinking driver."
- 35. As indicated in the brief, we are reviewing the adequacy of medical services starting with the needs of smaller communities.
- 36. We have, thus, indicated areas where continuing study and cooperation will result in a use of personnel and facilities to improve further the health services available for our people.

#### 37. RESEARCH

The need for an on-going program of research is a constantly recurring theme by all those interested in any aspect of health services.

- 38. It is our opinion that it is a proper function of government to supplement research funds provided by other interested bodies and that these research funds should be administered in the main by a body such as the Medical Research Council.
- 39. Grants to research workers should be such as to relieve their dependence on teaching or practice as a means of financial support.
- 40. The other important consideration is that grants for research should be for sufficient length of time to avoid frustration and waste and at the same time attract and keep trained research workers in our country.
- 41. We commend the needs in this area for your serious consideration.

#### 42. PREPAYMENT MECHANISMS

We have been impressed by the rapid expansion of prepayment mechanisms in our province. In 1950, 26% had surgical coverage and 14% medical. Ten years later these figures had risen to 63% and 59%, respectively.

- 43. We have commended our insuring agencies for their efforts to continue further expansion by such methods as individual, group, and community enrolment and the pooling of high cost individuals.
- 44. The coverage of indigents through the Medical Welfare Plan has been explained. Our recommendation is that those falling into the marginal income group should be added to the Plan. They are able to supply their other essential needs but have not funds to prepay or pay for their medical care and, therefore, may be reluctant to seek it.

- 45. We are confident of reaching the goal of universal availability of plans which will meet the needs of our people within the foreseeable future. That being so, there would not appear to be any reason for recommendations in this field that government go beyond its normal function of assisting those unable to assist themselves.
- 46. The funds which any government can raise through the various forms of taxation are limited. Therefore, the amount of money available from government for health services will always be limited. It becomes a question then, of where these limited funds can be used to promote the greatest improvement in health services.
- 47. We have given this question the serious consideration it deserves and have stated our opinion that priority should be given to the improvement in the management of mental illness as this is our most serious health problem; and to the provision of adequate health services facilities and the recruitment and education of sufficient personnel for all health services.

### SUMMARY AND RECOMMENDATIONS

## INTRODUCTION

- (i) The members of our Association join with other workers in the health field in welcoming you to our province. We appreciate the magnitude of your task. To assist you, we are presenting information and our Association's opinion about some of the matters detailed in your terms of reference.
- (ii) We have here representatives of our Association who will amplify any matters herein recorded. Questions relating to areas where a policy has not been established will be answered in writing after due consideration has been given to them.
- (iii) It should be recognized that some answers will be expressions of opinion only. Our Association is not equipped to develop statistical material related to costs, which is not immediately available to it. We regret that it was not possible for you to accede to our request to table the results of your research studies for scrutiny, interpretation and comment prior to the closing of the public hearings.
- (iv) Information obtained from the research studies could play an important role in shaping your recommendations to the federal government. For that reason we believe it should be made available prior to the completion of your deliberations. This would provide an equal opportunity for all interested groups and individuals to make further submissions, if it seemed appropriate to do so, in the light of the additional information.

(v) We have tried to be very candid throughout our brief in drawing attention to problem areas and indicating the consideration which our Association has been giving to them.

#### SUMMARY

- (vi) Scientific advancements, the development of various health programs and the willingness of citizens to underwrite the costs in some areas and of government in others, have all combined to improve and expand health services in our province. In other words, it has been progress by evolution as those providing, receiving and underwriting the services reached a basis of common understanding. It is our belief that this method of improvement and expansion has provided a solid foundation on which substantial progress has been made year after year, and upon which future developments should be based. (paras. 5-7)
- (vii) The role of the physician in private practice has been emphasized in the progressive development of improved health services. At the same time, it has been pointed out that his contribution has been made in co-operation with many other professional and allied groups and agencies, governmental and voluntary.

  (paras. 8-37)
- (viii) While the basic pattern by which health services are brought to our people has not changed greatly, there have been refinements and modifications in keeping with scientific development and changes in philosophy and economics.
- (ix) One of these has been the development of mechanisms whereby there is a pooling of manpower, e.g., partnerships, groups and clinics, as a method of practice, and the organization of

specialized units to cope with complex clinical problems in some hospitals, e.g., respiratory and cardiovascular units.

(paras. 38-45)

- (x) An indication of the scope of our Association's continuing interest in health services has been outlined. We have attached as appendices current reports of some Committees and Sections to indicate the depth and comprehensiveness of study undertaken in attempting to find solutions for problems in different areas.
- (xi) We have emphasized the importance of the work accomplished by many committees of our Association in enhancing the quality of medical care. Acknowledgement has been made of the co-operation and assistance received from departments of the provincial government and voluntary agencies in this endeavour.

  (paras. 82-100)
- (xii) The importance of sufficient personnel in the health field has been emphasized. Attention has been drawn to the small percentage of students, (7.6 percent of those entering secondary schools,) who acquire the qualifications necessary for training in medical and para-medical aspects of health services.

  (paras. 48-51 and 150-174)
- (xiii) Some of the reasons for not choosing medical or para-medical careers have been set down. The necessity for longer range planning for the personnel requirements of the future and the facilities and staff required for their education have been stressed. (paras. 52-58)
- (xiv) We have advocated that the remuneration of para-medical workers be reviewed by their professional associations in

- collaboration with the Ontario Hospital Association, the Ontario

  Hospital Services Commission and our Association. (para. 174)
- (xv) The shortage of physicians in the public medical services due to inadequate salary levels has been pointed out. It has been suggested that correction of this situation would improve these health services and reduce the loss of these physicians through emigration. (para, 59)
- (xvi) We have indicated areas which require further study, e.g., undergraduate education of students, student subsidy, postgraduate training and continuing education of general practitioners and specialists, and the distribution of physicians. (paras. 61-72 and 107-117)
- (xvii) We have indicated our desire to have the assistance of the universities and the Department of Health in continuing a study of medical needs of smaller communities. Our Association has started a special study to seek information in this important area. (para. 73)
- (xviii) The change in the management of patients with mental illness has been stressed and the developments necessary in this field to remove all disparity in treatment between mental and physical illness has been outlined. (paras. 175-178)
- (xix) Information gained from a one-year survey of handicapped children, conducted by our Association, has been filed. The need for, and our interest in, identification and registration of handicapped children has been stated. The need for a council made up of representatives from health, education and welfare,

- for the purpose of co-ordinating agencies and programs and integrating services, has been emphasized. (paras. 91-95)
- Our approval of the flouridation of public water supplies; the need for health units in some areas where they do not now exist; and the importance of clean water and sewage disposal have been outlined by our Committee on Public Health. (Appendix #19)
- (xxi) The shortage of facilities, including hospital beds and domiciliary accommodation, has been noted and recommendations made to assist in correcting this situation. (paras. 118-128)
- (xxii) We have suggested that the problem of transporting patients for continuing treatment should be the subject of further study by the voluntary agencies. (paras. 135-141)
- (xxiii) We have stated our intention of calling a conference on ambulance services and have suggested participation by the Ontario Hospital Association, the Ambulance Operators'
   Association and the Ontario Hospital Services Commission.
   (para. 137)
- (xxiv) The problem areas in rehabilitation as delineated by those attending the Association's second conference, held in March 1962, are outlined. The need for the appointment of a provincial co-ordinator and for greater community interest in this field have been emphasized. (paras. 33-37)
- (XXXV) We have described home care plans in our province and indicated the need for further study and evaluation.

  (paras. 129-134)

- (xxvi) We have emphasized that continuing improvement in health services requires an on-going program of fundamental and clinical research. (paras. 241-245)
- (xxvii) Our Association's opinion about the proper role of government in the field of medicine, has been outlined. (para. 143)
- (xxviii) The history and development of medical services insurance in our province have been reviewed. The rapid progress made and the advantages of a system of competing multiple carriers have been stressed. The approaches and proposals to assist in making available insurance mechanisms to those not eligible at present have been outlined. The contribution of the medically sponsored non-profit service plans has been emphasized.
- (xxix) We have stated our resultant opinion that all these carriers should be encouraged to continue. (paras. 179-240)
- (xxx) We have indicated the willingness of the profession to provide care to all citizens regardless of economic status. We feel that government is fulfilling its proper role when it assists those unable to provide for themselves because of economic circumstances. The profession has co-operated in caring for these people by helping to underwrite the cost of their medical care through the Medical Welfare Plan.
- (xxxi) For reasons described in this brief, we believe the Medical

  Welfare Plan should be expanded to include those who can support
  themselves but who cannot afford to either pay for or prepay the
  cost of their medical care. (paras. 198-201)

- (xxxii) In this situation, there would not appear to be any reason for government to destroy the existing insurance industry in this field, by going beyond its normal function of providing health services insurance for those unable to provide it for themselves.
- (xxxiii) Moreover, we are aware that the financial resources of government are not unlimited. Thus it would seem wise and prudent to direct the remainder of the available funds toward health services which individuals or communities cannot provide for themselves.
- (xxxiv) We have suggested that, in the use of these available funds, priority be given to improvements in the management of mental illness, the provision of adequate health services facilities and the recruitment and education of sufficient personnel for all health services. (paras. 246-248)

#### THE ONTARIO MEDICAL ASSOCIATION RECOMMENDS:

- 1) THAT the Department of Education, the universities and educational associations be commended for their concern about the small percentage of students entering secondary schools who complete Grade XIII and we recommend that they intensify their efforts to determine and correct the factors responsible for this situation.
- 2) THAT government provide funds for facilities and staff, through institutions teaching health personnel, so that sufficient may be educated to meet present and future needs.
- 3) THAT the financial requirements of students, training in the health field, be studied further by the teaching

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institutions, professional associations, and government.

- 4) THAT the Royal Commission on Health Services endorse
  the principle that all beds in any hospital operating under
  the Public Hospitals Act, other than those required for
  teaching units, should be available to every qualified
  physician in the hospital's area, within the limits of his
  individual competence.
- 5) THAT the autonomy of hospitals be preserved.
- 6) THAT the Royal Commission on Health Services endorse the recommendation, made previously by the Canadian Medical Association, whereby expenses incurred by physicians in attending post-graduate courses would be deductible for income tax purposes.
- 7) THAT the inadequate salary levels now in effect for physicians employed in the public medical services be corrected, thereby reducing the loss of physicians from these services, the province, and Canada.
- 8) THAT the determination of the need for hospital beds and domiciliary accommodation be a joint endeavour of the Ontario Hospital Association, the Ontario Hospital Services Commission and our Association. Further, that once need has been established, the cost be assessed against the federal, provincial and municipal governments according to a formula agreed upon by those governments.
- 9) THAT the amount and ratio of contributions of the federal, provincial and municipal governments to the capital costs of hospital construction be reviewed.

- THAT the cost of hospital construction assessed against
  a municipality should reflect the use made of the hospital
  by the residents of that municipality.
- THAT mental illness be recognized as our most serious health problem; that there be a change in approach to the management of the mentally ill to bring it into line with that of other illnesses, with particular reference to outpatient services, hospitalization, rehabilitation and insurance coverage; and that psychiatric research be expanded.
- 12) THAT a provincial co-ordinator on rehabilitation be appointed and given authority to direct government effort in this field; and that communities be encouraged to initiate local programs including the development of sheltered employment and workshop facilities.
- THAT there be an accelerated program of medical research supported by funds designated for that purpose and administered by an agency such as the Medical Research Council.
- 14) THAT priority be given to suggested improvements in the management of mental illness, the provision of health services facilities, and the recruitment and education of sufficient health services personnel.
- 15) THAT the efforts of the insuring agencies to provide satisfactory plans, through such methods as individual, group and community enrolment; through the right to

retain coverage on retirement; and through the pooling of costs of high risk individuals, be commended; and

We recommend continuing and intensified efforts by these agencies to achieve the goal of universal availability of such plans; and

We recommend that there be added to the rolls of the

Medical Welfare Plan, financed by the Department of

Public Welfare and administered by our Association,

those citizens, to be determined by mutual agreement, who

are unable to purchase medical services insurance because

of financial inability to do so; and

THAT those members of the community, who are financially able to do so, retain the responsibility of paying for or prepaying the cost of their medical services; retain the freedom of choosing whether to prepay it or not; and retain the freedom of choice of plan to meet their needs.



BRIEF

from

# ONTARIO MEDICAL ASSOCIATION

to

## THE ROYAL COMMISSION ON HEALTH SERVICES

1 9 6 2

- Mr. Chairman and members of the Royal Commission on Health Services.
- 2. The Ontario Medical Association was formed in 1881 and received a provincial charter forty years later. Membership is on a voluntary basis and is open to all graduates in medicine resident in the province.
  The 6,550 members at the close of 1961 included doctors from every geographic area, type of practice, and method of remuneration.
- 3. The objects of the Association, pertinent to this presentation, are as follows:
  - a) To cultivate the science of medicine and surgery;
  - b) To promote the public health;
  - To elevate the standard of medical and nursing education, both undergraduate and post-graduate;
  - d) To assist in the advancement of medical legislation for the good of the public and the profession;
  - To study the question of hospitalization and advance by any means in its power the improvement and standardization thereof;
  - f) To conduct or assist in conducting research work in connection with the different medical problems that from time to time confront the profession;

- g) To raise by general subscription from public and private bodies or persons and in any other proper or legal manner, funds for the proper carrying out of the objects herein contained, and to expend the moneys so raised in the furtherance of these objects.
- h) To serve humanity and the medical profession by investigation, study and research work in connection with all matters in which the profession can properly interest itself and to do any necessary act or things in the premises.
- 4. These objects show interest in the full range of health services; and the experience of the Association in implementing these objects over a period of 80 years form a firm basis on which to comment on the terms of reference of the Commission.
- The thesis of the Ontario Medical Association brief is a simple one.

  It will show that the continuous improvement in health services and health services insurance made available to our people has come about through the process of evolution; that in this development the private practitioner of medicine has played a leading part; that government, voluntary agencies and private corporations have had important supporting roles; and that further expansion and improvement is foreseen if this pattern is allowed to continue.
- 6. This basis of presentation should in no way be interpreted as advocacy of the status quo except as it relates to the environment in which tremendous accomplishments have been achieved in our province. It should be looked upon as the approach of those familiar with the development of medical science where progress has come about through trial and error, through discarding

and acceptance, through searching in this direction and that direction, and most important of all, through evaluation of whether on the basis of day to day application it meets the test of the need of the individual patient.

7. It may be argued that this approach of the scientific mind is too slow and all the deficiencies of our present program should be corrected at one fell swoop by a master organizer who would create instant perfection. Our experience has taught us, however, that in the context of medical care, perfection is as difficult to reach as it is to define. The peculiarities of the individual human being; the variations of his environment, his illnesses and his needs for care; the enlarging scope and methods of medical science and its unpredictable rapidity and direction of change, all contribute to the ever shifting evolutionary process and pose almost insurmountable problems of complexity to 'master organizers.'

# THE ROLE OF THE PRIVATE PRACTITIONER IN THE PROVISION OF HEALTH SERVICES

The settlement of Ontario by the Loyalists began in 1784. At first medical attention was given by British surgeons attached to the army and navy. Later some of these surgeons retired from the service and entered private practice; others came from Britain and together they established the method of practice which has continued to the present. Caniff in his book, "The Medical Profession in Upper Canada," says of these early physicians:

'The stamp of Englishmen who thus first practised medicine in Canada was as good as British medical education could at that time produce. That they were not wanting in knowledge, and a desire to introduce the latest discoveries in medicine is sufficiently attested.'

Now, almost two hundred years later, we could paraphrase and say that the private practitioners of Ontario are as good as medical education anywhere in the world can produce and their desire to give their patients the advantages of the latest discoveries has not abated.

- 9. The majority of personal health services; preventive, diagnostic, therapeutic or rehabilitative, are still provided in Ontario by or through a doctor who is in the private practice of medicine.
- It is customary in our province for citizens to have a personal or family physician. They depend on him to guide them in acquiring necessary health services. Some of these services he will provide without reference; some after consultation with a confrere. For those he cannot render, he will guide his patient in choosing a colleague or other required personnel and facilities. In any case, he will remain the central co-ordinating figure on whom the patient and his family will rely for information and advice.
- 11. It does not matter whether health services are given by the family physician or referred to a colleague. Each physician in turn accepts full ethical and legal responsibility for the quality of his services and the patient's welfare.
- This co-operative arrangement is the foundation on which private practice is built. The physician, while accepting complete responsibility for the care of his patient, acquires from and shares with colleagues associated with the case all information useful in the management of that illness.

This arrangement works to the advantage of the patient and his physician; to the patient because there is brought to bear on his problem the resources of a number of physicians while at the same time having one physician accept individual responsibility for his care; to the doctor because in the course of discharing his professional responsibility he shares in an educational experience which will be useful in the future care of that patient and others.

## PREVENTION

- 14. The private medical practitioner, in his daily contact with patients in office, home and hospital, practises preventive medicine. This may encompass inoculations against infectious diseases; advice about food, shelter and clothing; personal problems and family counselling.
- The physician, through knowledge gained from the history,
  examination and observation of his patients and their surroundings,
  is in the ideal position to give counsel and advice about preventive
  health measures. It is difficult to visualize any patient visit
  where advice about this aspect is not given. In fact, while the
  foetus is still within the womb, the physician gives the mother-tobe advice about the welfare of the infant and this counselling continues through to the grandfather, whose tenure on earth is
  dependent upon living within the reserves of a failing heart.
- 16. The part undertaken by the private practitioner in the field of preventive medicine is carried on so quietly day after day and year after year; is so undramatic and so incapable of measurement

in precise terms, that we tend to overlook the magnitude of the contribution being made.

- To practice this excellent type of preventive medicine, the physician requires two things in addition to professional competence; one is time and the other the confidence of each individual patient.

  These are the bulwarks of private medical practice and anything which is done to interfere with them will lessen the value of the private practitioner in this field. This is particularly true now when the tensions of the world are being reflected in feelings of individual insecurity, making the contribution of the family physician increasingly important in the prevention of mental and physical incapacity arising therefrom.
- 18. An increasing number (370 in 1961) of private practitioners are devoting part-time (306) or full-time (64) to the provision of preventive medical services to employees of industrial firms.
- 19. Employers, who pay for this service, are becoming aware that the maintenance and improvement of the employees' health results in improved morale, increased efficiency and productivity and reduced absenteeism. (See Appendix #1)
- 20. Local medical officers of health are seeking the services of private practitioners to assist in such preventive programs as immunization clinics and the examination of pre-school and school children.

## DIAGNOSIS

- The essentials required for making a diagnosis are a patient and 21. a physician. The steps required to arrive at a diagnosis vary from patient to patient but in general terms the first one is the development of a basis of mutual trust and respect between patient and doctor, followed by a confidential exploration of the history, symptoms, family, work and community situations, and the patient's adjustment to them. It continues with appropriate physical examination and such tests as are indicated and available in the doctor's office. It may go on from there to involve assistance from a number of professional and technical people and the use of intricate instruments and equipment, each helping to compile information about the patient. With few exceptions, however, the diagnosis cannot be made with accuracy until the responsible physician studies all the information in the light of his knowledge of the individual patient.
- 22. The assistance available to the practising physician in the field of diagnosis has grown with remarkable rapidity in the past two or three decades. It is a tribute to the ingenuity of man that at the present time few parts of the body remain inaccessible to the probing scientist.
- 23. We will not recite the details of all the advances in this area, but as the terms of reference specify facilities and methods by which diagnostic services are rendered, some comments would be in order.

- 24. The doctor in private practice tends to limit his acquisition of diagnostic equipment to items used frequently and which are not too complex in nature. There are exceptions to this such as the radiologist and pathologist who require an appreciable amount of costly equipment and technical help. A questionnaire was directed to the profession in 1958 seeking information about the number of doctors who had extra diagnostic facilities in their offices. Based on the replies, we estimate that exclusive of such items as microscopes, sphygmomanometers, ophthalmoscopes and auroscopes, 8% of the doctors own x-ray equipment; 12% own fluoroscopes and 18% own electrocardiographs. It is evident, therefore, that the private practitioner is providing a significant amount of diagnostic equipment.
- The hospitals in the province are becoming better equipped and the larger ones have extensive equipment to assist in the diagnosis of unusual and difficult problems. The increasing number of specialists has made it possible to provide improved medical services to outlying areas and it has become necessary for the hospitals in these areas to improve their diagnostic facilities.
- This decentralization of specialists and diagnostic facilities has reached a point where studies are being made in an attempt to balance the desire of each local community to have a complete range of diagnostic facilities in local hospitals against the total needs of the province. It is becoming evident that the most complex items will have to be centralized, likely in our teaching hospitals. This would appear to be reasonable in the light of their high cost, rapid obsolescence, the relatively small percentage of patients

requiring them, the scarcity of trained personnel and the competence which comes only with sufficient use.

## TREATMENT

- 27. All treatment is ordered by a physician. It may be given by him personally or by someone under his supervision. In either case, the physician is responsible for the co-ordinated program of management required for each individual patient.
- An important part of treatment is the confidence which a patient has in his physician. Sometimes this attitude develops quickly and with the first physician consulted. At other times a patient, particularly one with a psychosomatic or personal problem, consults several physicians before finding one in whom he can place his confidence. Once this attitude of trust is attained, it often continues for many years.
- 29. The majority of treatment starts and ends in the doctor's office or the patient's home. This is so because the percentage of serious illness is relatively small in relation to total patients seen. The hospital is the centre for treatment where facilities are required beyond the relatively simple ones available in the doctor's office.
- 30. Improvement in treatment has been remarkable because of many developments. The doctor in practice has had better training at both the undergraduate and post-graduate level. He has access to improved diagnostic facilities and an expanded program of medical research has not only made more definitive diagnoses possible but has been responsible for the advent of such advances as antibiotic

and other drugs, isotopic and radiotherapy, which allows him to use more specific treatment. Consultation services have become more readily available to him at the local level.

- 31. In hospital further assistance has been given by improved facilities; the development of technical skills; the additional scope and safety of anaesthesia; and the team approach whereby there is pooling of knowledge and skills.
- 32. Improved hospital by-laws, which delineate privileges in keeping with the training, skill and experience of the practitioner, and the hospital accreditation program, have set standards for all phases of hospital activity.

#### REHABILITATION

- being commensurate with his potentialities is part of the responsibility assumed by the physician who undertakes the care of that individual. The majority of patients, having relatively minor ailments of short duration, do not require a formal rehabilitation program; the minority, presenting severe physical or mental conditions, require diversified and prolonged programs.
- 34. The first step in rehabilitation is diagnosis; the second, assessment of the physical and mental condition and capacity of the patient; and the third is a review of the family, social, employment and economic background. This is followed by the development and execution of a program designed not only to restore the patient to his former condition and status but where possible, to exploit

previously unrecognized potentialities in physical and mental capacity and environment.

- To provide the opportunity for a patient to rehabilitate himself commonly requires the assistance of medical and surgical specialists, nurses, physic and occupational therapists, psychologists, medical social workers, teachers, speech therapists, craftsmen, vocational counsellors, placement officers, voluntary and government agencies. Success is usually dependent upon the co-operative effort of some of these or other groups but in rehabilitation, as in diagnosis and treatment, the personal physician must be the central co-ordinating figure to whom the patient can look for interpretation, guidance and encouragement.
- the co-ordination of the many services and personnel involved.

  Our Association's Committee on Rehabilitation has been concerned about the lack of co-ordination in the province for some time. It called a second conference on March 2, 1962, in order to define the problem areas and to find solutions. This conference was attended by representatives of interested groups and agencies including government departments, voluntary agencies and professional associations.
- of it are attached as Appendix #2. The Board of Directors of our

  Association, in reviewing them, was impressed by the need for a

  permanent co-ordinator of rehabilitation with authority to direct
  government effort in this field; the necessity of community

effort in the initiation and promotion of any local rehabilitation program; the need for the development of sheltered employment and workship facilities at the community level; the need for the medical profession to take more interest in and accept more responsibility for the initial and post-graduate training programs and working conditions of the para-medical groups; and the need for closer liaison between the limb and brace makers and the medical profession in order that the latter might receive more training in the application and availability of prosthetic appliances.

## GROUP PRACTICE

- The practice of medicine is changing with the times. Modern methods of transportation, the growth and development of hospitals, population expansion and urbanization, the rapid advance of medical science and the application of new knowledge and techniques have brought about conditions very different from those fifty, or even twenty years ago.
- One effect of these changes is that doctors have been brought into closer association with each other. One reason for this is that increased medical knowledge and its application to a greater number of conditions had led to utilization of more and more medical services. To meet this increased utilization and have time off for relaxation and study, doctors have entered into association with other doctors. Several arrangements have come about.
- 40. Some doctors remain in solo practice but have a working arrangement with two or three confreres so that when one is away, the others take the calls. A variation of this is for doctors to

share office accommodation and staff, while remaining in independent practice, but by mutual agreement cover each other for emergency calls. Another way is to have an emergency call arrangement for all doctors of a community with the members taking calls on a rotation basis. Still another way is for doctors to enter into a formal arrangement and practice as a partnership, group or clinic, where, depending upon the number so associated, one or more doctors can provide emergency services.

- 41. Another reason for closer association is that one doctor can no longer keep abreast of the rapid advances in the many spheres of medical practice. This has made each doctor more dependent upon his colleagues for assistance both in diagnosis and treatment.
- In our larger hospitals this has led to the team approach in the management of certain conditions and the development of so-called units where patients with these conditions are treated during the acute phase of their illness. An example is the respiratory unit where patients are sent who have respiratory distress whether from illness, accident or following surgery. Here members of a team which may include an otolaryngologist, an anaesthetist, an internist, a cardiologist and a surgeon are on duty until the patient has recovered.
- doctors but no well-defined pattern of group practice has become established in our province. Doctors are basically individualists and while some are comfortable in a group arrangement, many are not. Patients too, have not lost their desire for a personal physician, particularly with certain types of condition and illness.

- 44. Patients appear to accept group practice best where there is a stable group doing a family practice and the patient can look upon one member of the group as his doctor. They accept it less well where those responsible for providing routine care have a loose attachment to the group with resultant rapid turnover so that little or no rapport is established between doctor and patient.
- 45. The time has not arrived where one can predict with accuracy what the future development of group practice will be. Here again, we are evolving methods of practice to meet particular needs and as circumstances and needs change so will the pattern of practice.

## METHODS OF IMPROVING EXISTING HEALTH SERVICES

- our province was formed. There is no reason to believe improvement will not continue as there are areas that need strengthening. This improvement will evolve as understanding develops further among the profession, government, voluntary agencies and local communities.
- A few comments will be made on some of the factors bearing on the quality of personal health services along with suggestions of areas for further study.
- 48. The main requirement for good quality personal health services is a sufficient number of highly competent workers in this field.

  To acquire these we must look, first of all, to our secondary schools to produce sufficient graduates with the necessary qualifications to meet the demands of all groups in the province not just health workers.

- 49. In Ontario, 61,911 pupils enrolled in Grade 1X in 1955, but by 1960 only 18,447 were in Grade X111, a percentage of 29.8 (this figure is inflated somewhat as it includes students dropping back from previous years.) The figures of those graduating with nine Grade X111 papers are even more depressing - 4,718 or 7.6 percent of those starting Grade 1X.
- 50. When one considers that medicine, nursing, physiotherapy, laboratory technology, dietetics, occupational therapy, hospital medical record service, all require Grade X111 qualifications and that they have to compete with dentistry, engineering, pharmacy, law, theology, science, business administration and teaching, among other professions requiring high academic qualifications, one can see the real problem. There just are not enough qualified students graduating to meet the demand. The basic requirement is a review of our educational system and the factors responsible for such a small percentage of students completing Grade X111. Alternatively, we could lower the qualifications for entrance to training in the health field. Our view is that they have been raised gradually to cope with the increasing complexity of the work brought about by new scientific and technological advances. To lower them would lower the quality of health services provided and this would not be in the public interest.
- An adequate supply of students with proper qualifications does not in itself guarantee that our medical and other training schools for health workers will be filled with suitable students students with the quality of heart and mind which will be reflected in dedicated service of a high standard.

- 52. What makes a student enter or reject a certain profession; family tradition, natural inclination, the public image of the profession, the shadow cast before it? Some or all of these undoubtedly play a part.
- In an attempt to determine the reasons why students, who looked with favour on a medical career, were not going to apply, we obtained permission of the Department of Education to seek an answer from Grade XIII students. This was accomplished by having students from a sampling of schools across the province write a short note on the reasons why they were or were not going to seek entrance to a medical school. (See Appendix #3)
- of government control, were chiefly concerned with the high academic requirements, the length and difficulty of the course, the cost, the wrong choice of subjects and the arduousness of the physician's life.
- 55. We are concerned about the future supply of workers in the health professions because of a number of circumstances. Foremost of these is government intervention. Our government hospitalization insurance plan has been in operation only a little more than three years but already the averaging process of central control and authority is being felt. Hospitals are being told how many health workers of various classes will be allowed and the rates of pay which will be honoured. As hospitals are by far the largest employers of the majority of classes of health workers, there is little choice but to accept the dictates or change to some

other occupation. While many of those now trained will continue, our fear is that recruitment will become more difficult.

- The recent regulation extending the benefits of the government hospitalization insurance plan to include all follow-up care of fractures, seen originally at a hospital within 24 hours of an accident, is indicative of a trend to bring more health services under government control to the disadvantage of those engaged in private practice and ultimately to the disadvantage of the patient.
- 57. The socialistic beam being played on the health professions is casting a shadow which is becoming sufficiently large to be noticed by those contemplating the future. Even workers in the health fields are advising their children to consider the advantages of other occupations which so far have escaped the threat of socialization.
- Our concern for the future, expressed briefly, is that if government moves more and more into the health field and becomes more and more a monopolistic employer of health workers, not only will those already trained seek other employment but students contemplating enrolment will hear the cries of anguish and by-pass the health professions.
- The situation in our own province is portrayed in a submission,

  (Appendix #4), received from our Section on Salaried Physicians.

  The difficulty experienced in trying to improve public medical services is traced to our inability to attract and retain sufficient physicians at the inadequate salary levels now in effect.

- Our Section on Clinical Pathology in its submission (Appendix #5),
  expresses concern over the vulnerable position in which the
  discipline of clinical pathology will be placed if the autonomy of
  hospitals is lost and government thereby becomes a monopolistic
  employer of clinical pathologists.
- 61. Our future requirements of medical manpower have been tabled by
  the Canadian Medical Association (Royal Commission Exhibit #6)
  and ways of meeting these requirements will be commented upon
  by the Canadian Association of Medical Colleges and others competent
  to do so.
- From the point of view of the private practice of medicine, we would emphasize the importance of having an adequate number of properly trained physicians and recommend that priority be given to the implementation of the recommendations placed before the Commission by our universities.
- Even with an adequate number of physicians, improvement can be made in the provision of personal health services and we would like to comment upon some areas which, in our opinion, require further study.
- 64. Ideally, we would like to have the doctor with the right training in the right place at the right time to render required services. This visualizes not only a proper geographical distribution but also an appropriate balance between the number of specialists and general practitioners as well as among the various specialities.

- Organized specialist training in Canada is relatively new, having started in 1929 when the Royal College of Physicians and Surgeons of Canada was established with the assistance of the Canadian Medical Association.
- The number of specialists trained in the first few years was relatively small but there was a rapid increase after World War II. There were a number of reasons for this acceleration. There was obvious need for more doctors with special training to meet the challenge of the advances in scientific medicine; more specialty training programs were being developed and approved; veterans had some government funds to assist in meeting the cost and, having been uprooted by the war, many decided to take further training before re-locating.
- 67. The first result was an improvement in the quality of medical services in the larger centres and later a gradual improvement across the province as more specialists became available and moved to the smaller centres.
- In some specialties this program has not only met the need but produced so many that an increasing number can no longer restrict their practice to their specialty but must do general practice; in other specialties the number produced has not been able to keep pace with the demand. For example, the Section on Ophthalmology (Appendix #6), draws attention to the shortage of certified ophthalmologists. Thus we have had develop an imbalance both in ratio of specialist to general practitioner and in the specialty fields themselves.

- 69. This situation should not occasion surprise as it always takes some time to adjust to new developments. Changes are taking place gradually both in the general practitioner and specialist program.
- 70. The College of General Practice of Canada which was founded in
  1954, has been stimulating more hospitals to develop special internships designed to meet the requirements of modern general practice.

  This will increase the number and quality of general practitioners.
- 71. Requirements for specialist recognition are being raised in some specialties this year and in others in the near future. This will undoubtedly limit the number qualifying while at the same time improve the standard of specialty service. The profession has learned to meet problems as they arise and we are confident of a satisfactory solution
- 72. The problem of proper distribution of doctors is more difficult of accomplishment as there are a number of factors responsible:
  - The province-wide trend to urbanization which is reflected in the large proportion of medical students coming from large centres and showing little inclination to practice in the smaller communities, (Appendix #7); the majority of graduates of foreign medical schools have stayed in the larger cities where there are more of their fellow countrymen.
  - 2) The fact that the majority of medical students are married and many have young families prior to the completion of internship training makes the decision where to locate a family one, and the question of educational and recreational facilities plays a large part as well as the calibre of the house and office available.

- Consideration is given to the diagnostic, consultative and hospital facilities as compared with those available as a medical student and intern.
- 4) There is a tendency for interns, and particularly those who have taken advanced training, to start practice in the area where they have trained and so become known to the hospital and the medical staffs. Hospitals having sufficient bed capacity, staff and facilities to be approved for junior intern and specialist training programs, are of necessity located in the larger cities. The result is that a disproportionate number of doctors start practice in these larger centres.
- 5) Many doctors in the outlying communities have found themselves burdened with too large a work load but one not sufficiently large to warrant a partner. They have found difficulty in getting time off for rest and post-graduate training so important in a satisfying experience.
- 73. While a solution has not been found, discussions have been held with the Department of Health and the universities. Moreover, our Association is undertaking a research program in an endeavour to evaluate more fully the factors involved and to be in a position to initiate remedial action.
- 74. The enlarging scientific basis for the diagnosis and treatment of human ills makes it imperative for the physician to refresh his knowledge at frequent intervals. The practitioners in this province are fortunate in having ample opportunity to do so; the universities, our Association, the Canadian Medical Association.

voluntary and government agencies have all been active in arranging and assisting in the provision of post-graduate courses of all types.

- 75. Those provided at the local level create no problem. Those available only at distant centres require time away from practice, they incur travelling and maintenance costs, and they result in loss of income because income stops when the doctor is away.
- 76. To encourage attendance at these post-graduate courses, we would ask the Commission to endorse a recommendation which the Canadian Medical Association made to the federal government whereby expenses incurred in attending these courses would be deductible for income tax purposes.
- 77. It is difficult for the doctor to keep his scientific knowledge in good repair if he does not have that association with his fellow practitioners which comes from attending his patients in hospital.

  Fortunately, throughout most of the province a doctor has this privilege, within the limits of his competence as judged by his confreres. In the larger metropolitan areas, however, where there is an acute shortage of hospital beds and a rapidly expanding population, some doctors have found it impossible to either become associated with a hospital or to have an association which is meaningful from the practical standpoint of personally admitting patients to hospital.
- 78. Our Association has made a forthright statement about this matter in these words:

"the individual physician must have the right to treat his patients in and out of hospital within the limits of his competence as judged by his confreres."

- 79. We believe this to be essential in the long range improvement of personal health services. At the same time we realize the necessity of our university hospitals having sufficient beds under the sole jurisdiction of the university staff in order to train the increased number of physicians required in our province. The problem will not be solved until the number of beds in these areas is sufficient to meet the total need.
- Improvement in health services requires continuing self-discipline of the profession. The College of Physicians and Surgeons of Ontario is responsible for administration of the Medical Act which includes a disciplinary function. Matters within the jurisdiction of the College, however, pertain only to improper, infamous or disgraceful conduct in a professional respect. While these are important areas and necessary for the protection of the public, there remains almost unlimited scope for measures of self-discipline beyond these restricted functions of the College.
- The Ontario Medical Association, as a voluntary organization, works in two ways to promote self-discipline. One is by recommending legislation; the other by education.
- 82. An example of the legislative approach is hospital by-laws for medical staffs. In 1950 a committee of our Association studied the possibilities in this area with the Department of Health and made

recommendations which form the basis of the present model set of hospital by-laws. The application of these by-laws, modified as necessary to meet specific needs of the local area, has improved the quality of care in hospital through more careful delineation of privileges and more thorough review and assessment of the medical care being rendered.

- More recently, the coroners of the province came together under the aegis of our Association. A section was established and a study undertaken which revealed need for a thorough review of the legislation as it pertained to the duties, responsibilities and remuneration of coroners. The co-operation of the Attorney General's Department was enlisted and a special committee formed. This committee held meetings in various areas of the province and invited all interested parties to make recommendations. The final result was a major revision of the Coroners' Act in 1961.
- legislative approach has been made possible by the co-operative effort of the Association and the Government. Without elaborating further, it is worthy of note that the history of the development of legislation in our province, as it concerns health matters, will reveal that two-way communication and consultation has been the rule rather than the exception. This has resulted in legislation which is usually practical in application and thus has the support of the profession.
- 85. The educational approach typifies the work of our Association.

  While not as dramatic as the legislative method, it has a greater

cumulative effect as its success depends upon the acceptance of personal responsibility by the individual members of the profession.

- 86. The Maternal Welfare Committee (Appendix #8) has reviewed every maternal death in our province since 1958. This has been possible only by the fullest co-operation of the Departments of Vital Statistics and Health. All maternal deaths are channelled to members of the committee who are consultants to the Department of Health. A member of the committee, or another certificated obstetrician, visits the area where the death occurred, talks to the doctor, examines the hospital chart and usually meets with the hospital staff. His travelling and maintenance expenses are paid by the Department and an honorarium, to compensate him for his loss of time is given by our Association.
- 87. As a result of the information compiled by this exhaustive study,
  the committee has been able to make recommendations to the
  profession which have resulted in a lowering of maternal mortality
  and morbidity. Unfortunately, recommendations made to the
  public about the dangers of criminal abortion have not had an
  appreciable effect to date.
- 88. At the suggestion of the Department of Health, a committee on

  Mortality Associated with Operative Procedures was established
  in 1958. Limiting itself to deaths occurring in the operating room
  or within 24 hours thereafter, the committee has reviewed over
  600 such deaths. In addition, the committee has had reported to it
  all untoward happenings such as fires, explosions, cardiac arrests,
  etc.

This careful review has placed the committee in a position where recommendations made to the profession have been acted upon with alacrity.

- In 1956 the Committee on Child Welfare became concerned about the mortality and morbidity associated with haemolytic disease of the newborn. With the financial assistance of the Junior Red Cross and the co-operation of the Department of Health, the Canadian Red Cross Blood Transfusion Service and the hospitals of the province, a thorough study was undertaken over a two-year period.
- 90. The result was establishment of special treatment centres in hospitals located in strategic areas of the province; improvement in facilities for the early recognition of the Rh factor; the publication of a booklet outlining the aetiology, diagnosis and management of the condition and listing the treatment centres. A copy of this booklet, attached as Appendix #9, was sent to every physician in the province. During the past year the committee has done a follow-up study and will be reporting to the next annual meeting of our Association.
- 91. In 1959 the Committee on Child Welfare became more aware of the necessity of finding out how many children were handicapped and with what conditions and whether programs in effect were meeting the total needs in this area. A decision was made to conduct a survey.
- 92. By the following year financial assistance had been obtained from the Atkinson Foundation and a director in the person of

- Dr. L. W. C. Sturgeon, appointed. A conference of representatives from official and voluntary agencies was called to outline the purpose of the survey and enlist the co-operation of all interested parties.
- 93. The survey began late in 1960 and was completed one year later.

  A second conference was then called to consider the findings of the director and make recommendations arising therefrom. The report and recommendations are attached as Appendix #10.
- on Child Welfare, agreed to recommend to Council in May 1962, that our Association establish a co-ordinating council with representatives from the three broad areas of responsibility, namely: health, education and welfare, for the purpose of co-ordinating agencies and programs and integrating services. The Board was in agreement that our Association should make a study of the ways in which adequate identification and registration of handicapped children might be made effective.
- 95. The Board concurred in the Committee's recommendation that doctors, hospitals, official and voluntary agencies should be interested in prevention, diagnostic and treatment services, research and education; that para-medical treatment facilities including dental care on an ambulatory basis should be extended; that inter-personnel communications and integration of effort is a basic necessity; that there is need for the establishment of more hospital and community rehabilitation centres and workshop facilities; that research is needed in the field of social welfare

and a provincial directory is needed to indicate to individuals outside the metropolitan areas, where special services might be obtained.

- 96. The Committee on Medical Aspects of Traffic Accidents has been very active. A survey on ambulance services is mentioned elsewhere in the brief. The Committee's interest in other areas is contained in a report to the Board of Directors, filed as Appendix #11.
- 97. This interest includes research, driver education, driver fitness, safety devices with particular reference to seat belts and the necessity of having effective legislation to deal with the problem of the "drinking driver." At the present time, in co-operation with Cornell University, the Committee is developing a program of research into the causes of traffic accidents.
- P8. The Hospitals Committee keeps under constant review the responsibility of the medical profession in the operation of our hospitals. Anticipating the increased demand on hospital accommodation and services with the advent of the government hospitalization insurance plan, the committee recommended the establishment of Admission and Discharge, Pharmacy and Diagnostic Services Committees. The Admission and Discharge Committees have proven to be useful in assisting administration to utilize the hospital to the advantage of those needing it most.
- 99. Pharmacy Committees review drugs as they come on the market and advise hospital pharmacies about those to be carried in regular stock. This assists hospital pharmacies to stock a wide selection while at the same time avoiding duplication of identical drugs under different trade names.

- 100. Pharmacy Committees also review the cost of drugs used in the hospital and make recommendations about use and abuse as indicated. Diagnostic Services Committees have not been established because the increase in utilization of these services has not appeared to warrant them.
- Education is the root of self-discipline and our Association has 101. applied itself assiduously in this field. Forty years ago, a program of making speakers available to each county medical society was started with the assistance of a grant from the Canadian Red Cross Society. This program has been carried on continuously since its inception. At the present time it is a co-operative effort of the Canadian Medical Association, the universities which supply the majority of speakers, the county societies which arrange programs at the local level, and our Association which co-ordinates the program. The expenses of some speakers are paid by the O. M. A. education fund which receives an annual grant from the C. M. A., some by the universities, some by agencies such as the Ontario Heart Foundation, the Ontario Cancer Treatment and Research Foundation, the Canadian Arthritis and Rheumatism Society and others.
- 102. Self-discipline is required in determining charges to be rendered for medical services. The Association publishes a schedule of fees as a guide to the profession. The latest one which became effective January 1, 1962, was the result of three years' study by the Tariff Committee. For the first time fees were established for services rendered by all specialists as well as by general practitioners.

- The schedule is used by practitioners and by organizations which insure the cost of medical services. For this reason, complaints about fees are few and far between. To evaluate these, mediation committees have been established in each county medical society. Since their inception in 1953, these committees have rendered a valuable service by bringing about a better understanding between patient and physician in the great majority of cases.
- The Board of Directors of our Association, ever mindful of the responsibility of the profession for self-discipline in this area, passed the following recommendation which was endorsed by Council in January 1962:

WHEREAS the Ontario Medical Association has developed a complete fee schedule for general practitioners and specialists; and

WHEREAS this official fee schedule has been activated as of January 1, 1962; and

WHEREAS the Ontario Medical Association recognizes the right of the public and insurance carriers to develop methods of prepayment based on the official fee schedule;

THEREFORE, to make this possible, the Board of Directors recommends to Council

THAT it urge all practitioners to adhere to the official fee schedule except in unusual circumstances; and THAT it empower the Board to study methods of ensuring adherence to fees which are fair and equitable both to the patient and his physician.

- We have been speaking about personal health services and some of the factors which relate thereto. While there are many components, there are two very essential requirements: one, qualification, the other, the acceptance of personal responsibility. It follows then that satisfactory health services depend upon continuing freedom as only freedom places upon the individual the necessity of assuming personal responsibility.
- 106. We would be less than frank if we did not state the concern of the profession about any proposals which would in any way lessen the freedom of the profession, with the inevitable loss of the personal responsibility of the physician for his patient.

#### Qualification

- The details of the requirements for entrance to and graduation from medical school, the conditions under which registration to practice are granted, the training and examinations required to meet specialist standards and the educational program of general practitioners will all be tabled by other bodies for your consideration.
- Our Association is interested in all of these aspects as they affect
  the quality of practice and the availability of doctors to meet the
  needs of the community. We have been impressed by the changes
  which are taking place in medical education as our universities
  attempt to meet the challenge of the times. We have appreciated
  also the problem faced by the College of Physicians and Surgeons
  of Ontario in trying to equate the educational and practical
  qualifications of candidates educated and trained in a variety of
  situations around the world.

- Medical education and its application to practice has evolved over a long period of time to reach its present status. There are now under discussion further areas for consideration, some of which are listed hereunder:
  - The length of the medical course:
     Some feel it should be shortened by
    - a) reducing the number of years, or
    - increasing the length of the academic year to ten or eleven months, or
    - making the final year comparable to the junior intern year, or
    - d) some combination of these.
      Others believe that with the scope and complexity of medical knowledge it would be impossible to shorten the course and maintain the present academic standard.
  - 2) The qualification for and place of general practice:

    Some feel that in order to provide the proper qualifications for general practice, the present one year of compulsory internship should be raised to two; others that the rotating internship should be abolished and replaced by longer sessions in medicine, paediatrics, obstetrics and psychiatry. Still others that the general practitioner will become more specialized by taking extra training in one branch of medicine such as paediatrics, geriatrics, internal medicine.
  - 3) The qualification for and place of specialty practice:
    Some believe the length of training for some specialists should
    be shortened in order to produce an adequate supply of specialists

able to deal with the majority of diagnostic and therapeutic problems in communities across the province. Others are of the opinion that the proper role of the specialist is to act as a consultant, and in order to produce more of the highly competent specialists required for this function, the period of training needs to be lengthened and the certification examination abolished, thus making the fellowship diploma the only recognized specialist criterion.

Some believe the role of the para-medical worker should be expanded in order to free physicians from much of the routine work which is time-consuming. This would require higher qualifications and either more intensive or longer periods of training for health workers all along the line.

Others are of the opinion that to raise standards and increase the length of training of para-medical personnel would lessen the number entering these fields and so deplete further the already short supply. Furthermore, they are of the opinion that to designate others to render many of the personal health services

would weaken the bond between patient and doctor and result in

The qualification and place of para-medical personnel:

110. Medical education and qualifications have never remained static.

Changes have been and will continue to be made in methods and standards as knowledge and circumstances warrant.

a poorer quality of medical care.

Many groups will play a part in the evolutionary process in these areas. The public will play a dominant role through their selection

of general practitioner or specialist for day to day care. Their choice will be influenced by such factors as the terms and conditions of insurance contracts, the buoyancy of the economy and the ratio of general practitioners to specialists.

- The College of Physicians and Surgeons of Ontario could play a significant part through changes in the requirements for registration or through the development of a different standard for admission to its specialists' register than that of the Royal College of Physicians and Surgeons of Canada which is its present criterion.
- The Royal College of Physicians and Surgeons of Canada, through changes in the length of training required and the examinations set for candidates could have considerable influence on the number and types of specialists available.
- The universities and their affiliated hospitals could modify the picture through their ability to provide facilities and personnel and through the pattern of post-graduate training programs which they develop.
- The number and qualifications of students entering the health field will influence the pattern of development. The ability of the educational system to make them available and the ability of the professions working in the health field to attract, train and retain them will be important factors.
- Government could affect many aspects of these areas by such
  measures as the allocation of funds for educational and treatment
  facilities, support of teaching and subsidy of students; the

inauguration, financing and control of national and/or provincial medical services insurance plans; legislation changing the basis for admission, graduation and registration, and/or practice privileges of those providing health services.

The complexity of the areas under consideration and the fact that so many groups could play a part in finding an acceptable solution would indicate the need for continued study on a long term basis.

#### Hospital Beds

- 118. Personal health services rendered by practising physicians will be improved when we have an adequate number of hospital beds for those patients requiring such accommodation. In Ontario, the Ontario Hospital Services Commission is charged with ensuring:

  "the development throughout Ontario of a balanced and
  - "the development throughout Ontario of a balanced and integrated system of hospitals and related health facilities."
- There are two factors impeding the Commission. One, that moneys required for this purpose come from sources outside the

  Commission the federal and provincial governments and the local community; the second, that although the demand for hospital accommodation is dependent to some extent on the availability of domiciliary facilities, the development of this type of institution is the responsibility of another government department. The following chart, prepared by the Commission, shows the source of funds for hospital construction in Ontario:

CAPITAL GRANTS FOR PUBLIC HOSPITALS (In thousands of dollars)

Fiscal Year	Ontario	Federal	Total Grants	Community's share Estimated
1947-59*	94,143	25,467	119,610	250,000.
1959-60	9,761	5,897	15,658	30,000.
1960-61	12,405	5,991	18,396	35,000.
1961-62	12,447	9,500	21,947	40,000.
1962-63	12,500	9,000	21,500	40,000.
1963-64	10,000	7,000	17,000	35,000.
*12-year period				

- 120. It can be seen at a glance that the cost to the community is twice that of the combined contributions of the federal and provincial governments. Thus the decision to add to an existing hospital or erect a new one is dependent largely upon the ability and/or willingness of the local community to undertake the financial commitment required. Moreover, under the present federal-provincial agreement, no depreciation of the capital costs of hospital construction is recoverable in the approved operating budget of the hospital which becomes the responsibility of the Commission.
- In a municipality with a relatively stable population and where the majority of hospital beds are occupied by local residents, the present arrangement has not produced a serious problem.

  Difficulties do arise, however, in areas with a rapidly expanding population where funds for hospital construction have to compete with urgent requirements for schools, roads, water mains, and sewage disposal facilities; and where the personal pledges of the residents on behalf of the original hospital are not retired before a campaign for an addition is under way. The above situation is typical of the suburban areas which surround our larger metropolitan centres.

- Difficulties arise also in communities where a significant percentage of the hospital beds are occupied by residents of other municipalities which assume no responsibility for financial assistance in the construction of the hospitals. This situation pertains in a city such as Toronto, where the hospital and medical facilities are such that patients are funnelled in from all areas of the province.
- 123. While the financial agreements of the three levels of government are outside the responsibility of our Association, it would seem logical to us that:
  - The contributions of the federal and provincial governments should be reviewed in the light of current costs and the present responsibilities of the municipalities.
  - The responsibility at the municipal level should reflect the use made of the hospital by the residents of each municipality.
- 124. Surely the way to make it possible for the Commission to discharge its responsibility is for the government to make effective the terms of reference of the Commission so when it had determined, in cooperation with our Association and the Ontario Hospital Association, where and what types of hospitals are required, it could then assess the three levels of government an equitable share of the cost on a formula basis previously agreed upon by the three levels of government.
- To see how these proposals would work, let us examine the situation in the City of Toronto. It has 3.9 active treatment beds per thousand as compared with the provincial average of 5.0, (1960.)

  The local municipality has taken the stand it will not contribute

toward the cost of hospital construction. It is known that many beds in Toronto hospitals are occupied by residents of other municipalities and this is one reason for the attitude of the local municipality.

We are suggesting that the Ontario Hospital Services Commission should be in a position to say that the required number of beds will be built and the cost apportioned in a manner agreed upon by the three levels of government:

x% to the federal government
y% to the provincial government
z% to the municipal governments of the province with each
bearing a share in keeping with the percentage of beds
occupied by residents of that municipality as averaged over
the past five years.

- A policy of fiscal autonomy would be in keeping with the belief of our Association that no health services program will be successful unless those responsible for its administration have authority to raise sufficient funds to meet the needs of the program.
- Ontario. It is estimated that we require 2.5 to 3 beds of this type for each thousand population. At the end of 1960 we had reached a level of 1.8. The lack of this type of accommodation makes it difficult to move patients out of hospital as quickly as their condition warrants. An additional deterrent is the fact that once they leave hospital they have to assume personal responsibility for their accommodation and other benefits such as drugs, diagnostic tests and physiotherapy, which are part of hospital services under the government plan.

### Organized Home Care Programs

- Organized home care programs (Appendix #12), are relatively
  new in our province. So far as we can determine, the first one was
  started in Toronto in March 1958 under the sponsorship of the Social
  Planning Council of Metropolitan Toronto, the Ontario Hospital
  Association and the Toronto Academy of Medicine. The plan is
  administered by the Board of Health and sustaining funds are provided
  by a federal health grant.
- 130. With the co-operation of the New Mount Sinai Hospital and the

  Toronto Western Hospital, this home care program was expanded
  in September 1961 to enable patients to leave hospital sooner and to
  continue their care at home under supervision of their own attending
  physician. The expanded program is an extension of hospital care
  and provides the comprehensive care that patients would have
  received had they remained in hospital for a longer time. This
  program provides up to 60 days of home care.
- The Homemakers' and Nurses' Services Act, passed in 1958, offers home care on a more restricted basis as services are limited to those named in the Act. It has one distinct advantage, however, in that it is applicable in any municipality in the province which enters into agreement with the Department of Public Welfare.
- Under the provisions of the Act, both nursing and homemaker services are made available on a basis of need and the patient is expected to pay the full cost if able to do so. Otherwise, part or all is underwritten by the municipality on a sharing arrangement (roughly 50/50) with the Department of Public Welfare.

- 133. In the larger centres, the Victorian and St. Elizabeth Orders of

  Nurses have made a substantial contribution by providing home

  nursing services without regard to the patient's ability to pay. More
  recently, other voluntary agencies such as the Canadian Red Cross
  have made homemaker services available.
- The Association is confident that, as with other areas of health services, a satisfactory program will evolve after a further period of experimentation and evaluation.

#### Transportation

- A sick or injured person, who requires transportation, often presents a problem to the practising physician. There are two situations where this is particularly true: one is the highway accident casualty; the other, the patient requiring treatment at an office or institution on a continuing basis.
- The first situation was studied by the Association's Committee on the Medical Aspects of Traffic Accidents over a two-year period beginning in 1958. The report of this study is appended to this brief, (appendix #13). The recommendations contained therein have been approved by our Association and are worthy of consideration as the mortality and morbidity associated with highway traffic accidents are a cause for grave concern.
- 137. The Association proposes to broaden its study of ambulance services
  by calling a conference of such interested parties as the Ontario
  Hospital Services Commission, the Ontario Hospital Association,
  the Ambulance Operators' Association and the voluntary agencies.

- The second situation presents an entirely different problem.

  Generally speaking, there are four methods of transport: public,

  private, taxi and ambulance. The difficult cases are those who, for

  one reason or another, cannot use public transportation, do not own

  private, do not need an ambulance and cannot afford a taxi.
- 139. Some of the voluntary agencies are assisting. For example, the

  Cancer Society will arrange transportation for those requiring

  radiotherapy and the Arthritis and Rheumatism Society will provide

  physiotherapy at home.
- This is an area which will become less of a problem if home care programs become more universally available. In the meantime, the problem of transporting patients that do not require an ambulance would appear to be a useful study by the voluntary agencies.
- 141. Continued improvement in personal health services will be dependent in large measure on the number of personnel available to render these services.

#### Government

- 142. It is our understanding that the Government of Ontario is presenting
  a brief which will outline methods by which personal health services
  are provided by government to the citizens of Ontario.
- 143. In May 1959, the Council of our Association considered the place of government in the field of medicine. The conclusions, as adopted by that meeting of Council, are set down here for the information of the Commission:

"Our concept of the responsibility of government with regard to the health of the public is to ensure, in co-operation with, and on the advice of, the medical profession as a whole, that a high standard of medical care is available to everyone.

With these thoughts in mind, we should consider the proper role of government in the field of medicine. Central government has three advantages over any other section of the community, namely:

- i) Central view and authority.
- ii) The power to legislate.
- iii) The provincial treasury.

It seems logical that these aspects of medicine which fundamentally require any of these things are properly the concern of government.

- A. Aspects of medicine requiring essential province-wide view:
  - Sanitation, preventive medicine, and venereal and infectious disease control.
  - ii) Civil defence and disaster planning.
  - iii) The education of the public in health and hygiene matters.
- B. Aspects requiring the authority of legislation:
  - Legislative jurisdiction with respect to the licensing of doctors to practice medicine.
  - ii) Legislative jurisdiction over hospitals.
  - iii) Legislative standards for food and its handling, housing, drugs, and safety precautions in homes and factories, institutions, etc.
- C. Aspects requiring assistance from the provincial treasury:

- i) In situations where the individual is incapable of providing for himself because of -
- a) Indigency.
  - b) Chronic or permanent mental or physical disability.
  - ii) In situations where a particular community would otherwise shoulder the financial load for a project beneficial to the whole province
    - a) Medical education.
    - b) Medical research.
    - c) Facilities which are expensive or located in small number or centres, e.g. radiotherapy by Cobalt Bomb, etc.
    - d) Subsidizing hospital building and operating costs."
- Our Association and Government have worked together harmoniously in developing programs to improve personal health services in our province. The role of each changes with the times and this pliability has been a significant factor in the evolution of a high standard of health services in our province.

#### Voluntary Agencies

- We believe the majority of voluntary agencies in our province will be submitting briefs to the Royal Commission, either separately or as part of national briefs.
- We are of the opinion that voluntary agencies are developing a useful role in the evolution of health services in our province. In an endeavour to assist them, our Association offered to appoint a representative to the Board of Directors of each agency. This offer is being accepted by an increasing number each year.

147. Voluntary agencies in the health field are dependent upon the advice and guidance of the medical profession. Many members of our Association give this assistance by serving on medical advisory committees and/or boards of directors and advising upon and supervising research, service and educational programs. The Association is establishing a committee on Voluntary Health Organizations to study and make recommendations regarding all the activities of these organizations.

#### The Physicians' Desk Companion

- The practising physician is often faced with a situation where a patient requires services of one kind or another which are available through a government or voluntary agency. To assist the physician, the College of Physicians and Surgeons of Ontario and our Association published a compendium of information about such services in a booklet called the Ontario Physicians' Desk Companion. The material contained therein was provided through the co-operation of the organizations able to supply information at that time.
- This booklet was distributed to each physician in the province and a copy is given to each new registrant. A copy of the second edition, published in May 1960, is filed with this brief, Appendix #14, to indicate the services available and the interest of our Association in bringing this information to the attention of the profession.

#### PERSONNEL

#### Physicians

- The private practitioner has a personal interest in the supply of physicians. He realizes that his ability to give good quality medical care is dependent upon having sufficient doctors in his area to allow him to spend required time with each patient. His interest has been reflected in his support of his local medical society and our Association and the measures developed by them to foster and encourage a supply of medical graduates.
- The local societies have been active in two ways. An increasing number are underwriting scholarships for the support of local students entering medical school and members of the societies participate in "vocational days" sponsored by high schools and/or service clubs of the area.
- Our Association developed a medical exposition (Mediscope) in
  1959. This was shown in 1959 in the Queen Elizabeth Building at the
  C. N. E. grounds in Toronto and in 1961 as part of the Canadian
  National Exhibition. One of the purposes of this exposition was to
  attract students into the health fields.
- 153. Another purpose of Mediscope was public education about the structure and function of the body and the scientific methods used in dealing with common health problems. It was anticipated that these public showings would create interest in the establishment of a permanent health museum where students and others could gain some useful background knowledge in health matters.

- To provide financial support for needy students, our Association started a Bursaries and Loan Fund in 1959. As of December 31, 1961, \$9,000. had been distributed to the four medical schools for disbursement in the form of bursaries and/or loans and \$7,630. of this had been allocated to students. In February 1962 a further amount of \$4,000. was distributed from the Fund to the medical schools.
- These measures have been of assistance to our medical schools in keeping their classes filled to present capacity. They cannot, of course, overcome the problem of the additional facilities and staff required to meet future needs as outlined in the submission of the Canadian Medical Association, (Royal Commission Exhibit #6.)
- The Canadian Association of Medical Colleges and others competent to do so will outline what will be needed to meet the requirements in manpower set down by the Canadian Medical Association.
- 157. The figures which follow were obtained from the College of

  Physicians and Surgeons of Ontario. They give the physician

  manpower situation in our province as of January 31, 1962:

#### SCHEDULE #1 - REGISTRANTS BY AGE GROUPS

Year of Birth	Age Group # of	Registrants	Percentage
1886 or before	75 and over	260	2.8
1887-1891	70-74	279	3.0
1892-1896	65-69	394	4.3
1897-1901	60-64	540	5.9
1902-1906	55-59	692	7.5
1907-1911	50-54	772	8.4
1912-1916	45-49	1,039	11.3
1917-1921	40-44	1,273	13.9
1922-1926	35-39	1,713	18.7
1927-1931	30-34	1,479	16.1
1932-1936	25-29	669	7.3
1937 or later	24 and under	8	. 09
	age not known	64	. 7

## SCHEDULE #2 - COUNTRIES IN WHICH REGISTRANTS RECEIVED REGISTRABLE MEDICAL DEGREES

Canada	7,531	
U.K., Australia, N.Z., South		
Africa & U. S.	742)	
Eire	104)	18%
Other foreign	805)	
Total	9 182	

# SCHEDULE #3 - NUMBER OF REGISTRANTS CERTIFICATED BY OR HOLDING FELLOWSHIP FROM ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA

F.R.C.P.(C)	529
F.R.C.S.(C)	329
Certification	2,404

Attention has been drawn by the Canadian Medical Association to our dependence upon graduates of other than Canadian universities. It will be noted that 18% of our registrants are graduates of schools outside of Canada. This represents more than the total number of graduates from our Ontario schools in a five-year period. It is also of interest that 639 of the present registrants are over the age of 70, and 933 over the age of 65. Thus the equivalent of three years' output of our Ontario Schools is over what is considered to be a normal retirement age. This may be more important in future years because of the fact that doctors may now deduct for income tax purposes, contributions made to registered pension plans. What effect this will have on earlier retirement of physicians remains to be seen.

158.

One other item of some significance is the steady increase in the utilization of medical services. The rate of increase within our prepaid plans has been rather constant at about three to four percent per year. If this continues it will mean that our estimates of required manpower will have to be increased accordingly.

Physicians have been noted for working long hours. The questionnaire sent out by the Commission will give definite figures in this regard. Whether in the light of a general trend toward shorter hours, the profession will continue to put in the hours it has in the past is difficult to say. It may depend in large measure on the attitude of the members to the conditions under which they are working.

## 161. SCHEDULE #4 - DOCTOR POPULATION IN THE PROVINCE OF ONTARIO (not necessarily in practice)

Total number of doctors fully registered with the College of Physicians and Surgeons of Ontario (this figure does not include all interns)	9,182
Total number of doctors registered with the College of Physicians and Surgeons of Ontario but not resident in Ontario	1,046
Total number of doctors registered with the College of Physicians and Surgeons residing in Ontario	8,136

1 doctor for every 764 population

1 specialist for every 1,957 population

l general practitioner for every 1,254 persons

Number	Specialty	Ratio (1 doctor per # population)
257	Anaesthetists	24, 202
15	Bacteriologists	414,666
54	Dermatologists &	
	Syphilologists	115, 185
59	Gynaecologists	105,423
628	General Surgeons	9,904
487	Internists	12,772
22	Neurologists	282,727
18	Neuro-	
	psychiatrists	345,555
20	Neurosurgeons	311,000
100	Obstetricians	62,200
188	Obstetricians &	
	Gynaecologists	33,085
154	Ophthalmologists	40,389
84	Orthopaedic	
	Surgeons	74,047

4.44	04-1	44 110
141	Otolaryngologists	44,113
218	Paediatricians	28,532
100	Pathologists and	
	Bacteriologists	62,200
11	Physiatrists	565,454
23	Plastic Surgeons	270,434
221	Psychiatrists	28,144
44	Public Health	141,363
176	Diagnostic Radiologists	35,340
69	Therapeutic	
	Radiologists	90,144
11	Thoracic Surgeons	565,454
77	Urologists	80,779

- N.B. Some are specialists in more than one specialty.
- The 9,182 registrants listed by the College includes 1,046 who are not resident in the province which leaves us with 8,136 doctors licensed to provide personal health services. Of these, 4,959 are general practitioners and 3,177 specialists.
- approximately 1, 283 doctors who are on salary, the majority of whom are doing administrative work. To partially offset this, however, there are 1,050 interns assisting physicians to render personal health services in hospitals, the majority of whom are not fully registered with the College and so not included in these figures.
- The gross physician-population ratio of 1/764 compares favourably with the other provinces of Canada.
- 165. So far as we are aware, it has not been possible to state either the ideal physician-population ratio or the ideal ratio of general practitioners to specialists. There are too many variables to be taken into account.

- The number of general practitioners required depends upon the pattern of practice amongst other things. If specialists do general practice or even unreferred practice within their specialty, it reduces the requirement for general practitioners. If, on the other hand, specialists do consulting work only, more general practitioners are required.
- The number of specialists required is reduced if they do only referred consultations. The number required is increased, however, if general practitioners refrain from certain types of practice such as surgery and anaesthesia, for example.
- 168. Geography also plays a part as more doctors are required per capita in the province as large as Ontario with wide areas of sparse population. The number of fully registered practitioners required is influenced by such factors as the volume of patients treated at outpatient departments of hospitals, by public health departments, travelling clinics and voluntary agencies. It will be affected also by the role played by nurses and other health workers.
- It would seem safe to say that in our province those who seek

  medical services are able to obtain them. It is true that some

  patients have to travel farther than formerly but with modern means

  of transport they are probably closer on a time basis than in any

  period of our history.
- As mentioned earlier in the brief, our Association is now engaged in a study of the problems surrounding the provision of medical services to smaller communities.

#### Other Health Workers

- The manpower situation as it relates to other health workers will be tabled by other associations. The medical profession has a keen interest in the training of those who assist in the management of patients. In our opinion there must continue to be the closest liaison with our profession in the development of their training and registration programs in order that those working with our profession may be kept fully aware of the advances in medical science and the changing methods and techniques of diagnosis and treatment resulting therefrom.
- A questionnaire, directed to our branch societies, (Appendix #15), gave sufficient returns to substantiate the shortages in many categories of health workers which have been brought to your attention. The supply never seems to keep pace with the demand. The primary reason is lack of long range planning to cope with the expanding horizons of medical practice and the rapidly increasing population.
- 173. It is unfortunate when hospitals are built and furnished only to find there is insufficient nursing staff to open some of the wards for indefinite periods. As in the case of physicians, we have been dependent upon workers trained in other countries to augment the inadequate supply from our own schools. This is a tenuous position to be in.
- Another area of concern is the emigration of trained health workers 
  1,365 nurses, 28 dieticians and 116 medical and dental technicians
  emigrated to the United States in 1960. This suggests that

remuneration and working conditions need a thorough review. This is particularly true in the light of the fact it is almost impossible to interest males in these fields. This means we have a higher attrition rate than would pertain if we had a better balance between male and female workers.

#### Mental Illness

- The management of patients with mental illness is undergoing rapid change. New discoveries in the pharmaceutical field, new techniques in surgery, the use of electro-shock and other forms of therapy, more physicians with greater knowledge acquired through longer periods of specialized training and a changed attitude on the part of the public, have all combined to produce dramatic improvement in psychiatric care.
- This new approach makes older methods seem more obsolete than time would suggest. The large mental hospital, isolated geographically from the general hospital and medical community, providing custodial care to patients with little hope of returning to their homes and families, seem as out of date in the modern concept as a thigh amputation without anaesthesia.
- To take full advantage of what can now be done in the treatment of mental illness, certain changes will have to be made gradually over the next few years. These include:
  - Emphasis on outpatient facilities and programs at the community level.
  - The development of a hospital system comparable to general hospitals:

- a) smaller units, community based (closely allied with general hospitals).
- b) administration by a local board of trustees.
- financing through the Ontario hospitalization insurance program.
- d) staff organization and function under by-laws approved for each hospital.
- 3) The development of a pattern for the provision of and insurance for medical services in keeping with what now pertains for the physically ill.
- Working conditions and remuneration which will attract and keep the required number of qualified personnel.
- The submission prepared by the Section on Psychiatry (Appendix #16) gives a complete picture of conditions as they exist and recommendations for improvement in the future.

#### THE METHODS OF FINANCING HEALTH CARE SERVICES

- The traditional method of financing medical services in our province was by cash at the time services were rendered or by post-payment in lump sums or instalment. In the early days this was sometimes money and sometimes goods or services. It was an arrangement between the provider and receiver of the services without reference to any third party.
- Over the years many mechanisms of pre-payment have been developed but for the majority of our citizens the financing of personal health services remains the responsibility of the individual and the arrangement for payment is a matter of agreement with his physician.

#### Lodge Practice

- One of the first methods of pre-payment was so-called 'lodge'
  practice. The members of a club or lodge would engage the services
  of a physician, pay him so much per member per month and in return
  expect him to provide all the medical care for themselves and
  sometimes for their families as well. As the definition of medical
  care often included drugs, hospitalization charges, diagnostic tests,
  specialist services and special nursing care, it provided a very
  comprehensive range of benefits.
- It was a poor arrangement as usually both parties to the agreement were out to protect their investment. The members demanded services, feeling they had paid for them and the doctor often denied service feeling the remuneration was inadequate. These differences arose particularly in regard to services such as drugs, hospitalization, diagnostic and specialist services which the doctor could not supply personally but was required to pay for.
- In spite of scathing denunciations by our Association, starting in

  1890, the practice continued and spread to industry. The reasons were
  two in number. One was that management and labour were attracted
  by a plan which appeared to provide comprehensive benefits on a service
  basis for a modest monthly fee; the other, that doctors starting
  practice were attracted by a steady basic income and well established
  doctors saw the possibility of making some money by taking on a number
  of such contracts and hiring recent graduates at low salaries to
  provide the services.

This type of pre-payment plan gradually disappeared after the introduction of plans which allowed subscribers free choice of doctor.

A vestige still remains in unorganized territories where the law requires employers of labour in lumbering camps, mining camps, on railway construction works and other works where labour is employed, to enter into a medical contract for the employment of a duly qualified medical practitioner to undertake the medical and surgical care and treatment of his employees; or establish a scheme or enter into an arrangement for the medical and surgical care and treatment of his employees. The advent of improved roads will soon render this unnecessary as many of these workers now live in communities with their families and are driven to work each day in a company bus.

#### Closed Panel Clinics

A closed panel clinic which may be established and administered by either management or unionic a variation of 'lodge' practice. It is an arrangement whereby benefits are provided to employees and usually their dependents by physicians employed by the clinic. The benefits may be restricted to diagnostic services or be comprehensive to include home, office and hospital care. The physicians may be employed on a full-time, sessional or fee-for-service basis. It is similar to 'lodge' practice in that workers and dependents are limited in choice of doctor to those employed by the clinic; it is different where doctors are employed full-time by the clinic and thus limited in their choice of patients to those eligible for benefits.

The Ontario Medical Association, after an intensive study of closed panel clinics, arrived at the following conclusions:

"That while the operation of a closed panel clinic need not contravene the principles approved by the Association as a means of providing medical care, closed panel clinics give rise to concern in the following areas:

- a) The quality of a patient's care could be seriously affected by the restriction of his choice of physician where in a particular problem the best medical care is available only outside the clinic. Conversely, the best medical care could be denied a patient who is not a subscriber in the plan.
- b) That a point could be reached where the clinic doctors would be such a considerable percentage of the medical profession in an area that:
  - i) the policies of the local medical society and of the standing committees of the medical staffs of hospitals could be-controlled by the clinic doctors. This would cause concern only if the interest of the clinic superseded the interest of the community or interfered with the rights of the individual physician.
  - ii) unless the clinic carries its fair share of the community medical care of medical indigents in the home, office and hospital, the doctors outside the clinic may be placed in an untenable position.
- c) There is a danger of lay interference in medical practice.
- d) There is a danger that a fixed budget may adversely affect the quality of medical care.

- e) There is the possibility of denial of the privilege of the patient and/or the doctor in the clinic to approach the mediation committees of the profession.
- f) There is an element of danger in any contractual relationship. In a contractual arrangement with a closed panel clinic, experience has shown the wisdom of a sound written contract designed to protect the doctor's rights and privileges."
- In the light of these conclusions, the Council of the Ontario Medical

  Association adopted the following resolution:

"THAT the Ontario Medical Association believes that the system of closed panel clinics is not the best available method of providing medical care, having in mind the interests and total health needs of the citizens of the community."

Workmen's Compensation Board, and other limited plans

There are a number of service plans in Ontario which confine their benefits to a class of citizen and/or a type of illness.

The Workmen's Compensation Board is an example. Benefits are available to those eligible under the Act. Medical Services are limited to the care of accidents and illnesses arising out of employment. The Board allows initial free choice of physician but has the authority to transfer patients from one physician to another and to employ physicians to render medical services. Once accepted by the Board the patient has no responsibility for the payment of his medical account and the physician in accepting the patient, understands

his total fee will be that allowed and paid by the Board. Other examples would be Veterans, Indians and Mariners who are cared for through departments of the Federal Government.

#### Government Hospitalization Insurance Plan

- 189. Residents of Ontario insured under the Government Hospitalization

  Insurance Plan are entitled to certain medical services, to wit:
  - Medical services required by patients admitted to an Ontario Government Mental Hospital.
  - Medical services required by patients admitted to an approved tuberculosis sanatarium.
  - 3) The following medical services (if available) required by patients admitted to a hospital approved by the Ontario Hospital Services Commission:
    - a) Radiotherapy
    - b) Diagnostic Radiology
    - c) Clinical Pathology
    - d) Cardiology taking and interpretation of electrocardiographic tracings only.
    - Neurology taking and interpretation of electroencephalographic tracings only.
  - 4) The services outlined in (b), (c), (d), and (e) above, if required, as the result of an accident and if requested by registering as an out-patient within 24 hours of an accident.
  - 5) Follow-up care of fractures treated originally at a hospital emergency department within 24 hours of an accident.

190. While radiotherapy provided by any clinic operated by the Ontario

Cancer Treatment and Research Foundation to a patient on an outpatient basis may be charged for, the application of a means test is
applied in a manner which assures treatment to every citizen
requiring it.

#### Medical Welfare Plan

- 191. Residents of Ontario become eligible for medical services under the Medical Welfare Plan if they are recipients of:
  - Old Age Security Pensions and are able to establish economic need.
  - 2) Old Age Assistance allowance.
  - Disability allowance.
  - 4) Allowance for the Blind.
  - 5) Mothers' Allowance (including dependents.)
  - 6) Allowance under the Rehabilitation Act.
  - 7) General Welfare Assistance (includes dependents.)
- The Medical Welfare Plan was established in 1935 under an agreement reached by the Department of Public Welfare and the Ontario Medical Association. Initially the plan included only all recipients of relief (general welfare assistance) in the province; in 1942 recipients of Old Age Pensions, Blind Pensions and Mothers' Allowances were added; in 1952 recipients of Old Age Assistance allowances and Disabled Persons allowances were included; in 1959 recipients of allowances under the Rehabilitation Act were accepted.

- 193. The Department of Public Welfare is responsible for identifying those eligible and payment to the Association of an agreed sum per month on behalf of each person so named. The Association administers the plan and undertakes to divide the money equitably among the physicians who render the medical services stipulated in the agreement. Since the inception of the plan, these services have been restricted to those rendered in the doctor's office and the patient's home.
- 194. The per capita allowance by the Department has gradually increased from 25 cents per month in 1935 to \$1.25 in 1959.
- 195. At December 31, 1961, the Medical Welfare Plan listed eligible persons as follows:

69 556

Old Age Security	02,000
Old Age Assistance	19,652
Blind	1,397
Disabled Persons' Allowance	13,096
Mothers' Allowance	35,492
Rehabilitation Services	219
General Welfare Assistance	89,000
Total	221,412

- 196. Payments to doctors have varied and the table in Appendix #17 compares the years 1956-1961, inclusive.
- 197. A more detailed statistical analysis of the plan for 1961 is found in Appendix #18.

198. The January 1962 meeting of the Council of our Association, in approving a report based on a study in this area initiated in 1959, authorized the Board of Directors to:

"initiate discussions with the Government of Ontario with a view to implementation of an enlarged Medical Welfare Plan to include the marginal income group."

- This resolution is in keeping with the history and spirit of the plan whereby over the years groups of individuals, who could not afford to insure themselves, have been added to the plan and given the benefit of a service agreement. Whereas, heretofore, those added to the plan have been in receipt of a pension or allowance from some level of government, this new proposal would add a group who are able to provide the other necessities of life but unable to prepay or pay the cost of medical services.
- The Association has made this proposal in the interest of those in this economic category who might refrain from seeking medical services because of inability to pay for them and in furtherance of its policy of working toward universally available pre-payment mechanisms.
- The attitude of our provincial government, as expressed by the

  Minister of Public Welfare to the Executive Committee of our

  Association, was acknowledgement of need in this area and a desire
  to co-operate. He stated however that, for financial reasons, his
  department would be unable to do so until such time as the federal
  government made an appropriate contribution toward the cost.

The plans of pre-payment divide themselves into two broad types service and indemnity. A service type of prepayment plan is one
which entitles the subscriber to a specified range of medical services
without payment of a fee at the time service is rendered. Physicians
providing the services are paid by the underwriting agency and the
method with our plans is fee-for-service. An indemnity type of
prepayment plan is one which indemnifies the subscriber up to a stated
amount when a specified range of medical services has been
rendered to him. The subscriber is responsible for the payment of
his physician's account. In our province at this stage of the evolution
of prepayment mechanisms there are many examples of each type and
reference will be made to some in each category.

#### SERVICE PLANS

202.

#### Windsor Medical Services

- Windsor Medical Services is a non-profit service plan which commenced operation in 1939 under the sponsorship of the Essex County Medical Society. It sells a plan which provides very comprehensive benefits including general practitioner and specialist services and on a service basis to those with incomes below \$7,000. single, or \$10,000. married. This plan is available to groups and individuals in the counties of Essex and Kent.
- 204. We understand the Windsor Medical Services is presenting a brief and will elaborate further information about its growth and development. We would remark that this plan was the prototype for the majority of physician-sponsored service plans now operating in Canada and the United States. This may be because it incorporates

certain features which may prove to be important in providing a plan satisfactory to the majority of the population, to wit:

- It is a service plan for the lower but an indemnity for the higher income group.
- 2) It insures both general practitioner and specialist services.
- 3) It has local control and administration.
- It is sponsored, approved and underwritten by the physicians who provide the services.

#### Physicians' Services Incorporated

- 205. Physicians' Services Incorporated was established as a separate nonprofit corporation by the Ontario Medical Association in 1948 for
  the purpose of providing the people of the province with a mechanism
  through which they could prepay the major part of the costs of
  medical services. The details of the corporation's activity are
  contained in a brief submitted by Physicians' Services Incorporated.
- 206. Physicians' Services Incorporated varies from Windsor Medical Services in the following ways:
  - It is province-wide.
  - 2) It has central administration.
  - 3) It covers only general practitioner services on a service basis, (below income limits of \$7,000. single, and \$10,000. married.)
- 207. Specialist services have been covered to the extent of the general practice tariff and specialists have been allowed to extra bill for the difference between the allowance and their fee. Since the approval of a specialists' fee schedule, modifications are being made in plans

offered by Physicians' Services Incorporated to include more specialists' services as benefits.

- 208. The Ontario Medical Association has looked to Physicians' Services
  Incorporated to be the means through which, by experimentation,
  methods could be found to make prepayment of medical care
  available to all citizens of the province who wish to purchase it.
  This experimentation has proved useful and has been made possible
  because of two conditions:
  - 1) Community rating
  - 2) Account pro-rating
- 209. Community rating means that the premium rate struck is the average required to insure all people in the province as opposed to experience rating where each particular group is assigned a premium rate in keeping with the cost experience of that group.
- It may be argued that community rating leaves the corporation in the vulnerable position of having low cost groups insure themselves through other carriers who apply an experience rate, with resultant inflation of the community rate to a level where it would become non-competitive. While this is theoretically true, and indeed might be true if all things were equal, it has not proven to be so because of the willingness of participating physicians to accept as full payment a pro-rated fee.
- The agreement which the participating physician signs with

  Physicians' Services Incorporated gives the corporation the right to

  pro-rate the allowed account whatever percentage is required by the

  financial position of the corporation. Almost since its inception,

Physicians' Services Incorporated has stabilized the pro-ration at 90% of allowed accounts which means, in effect, that the participating physicians have underwritten the cost of administration and helped build up the reserves of the corporation.

- This co-operative effort of the participating physicians has allowed

  Physicians' Services Incorporated not only to keep the community

  rate at a competitive level but also to insure groups in the

  community at that rate who ordinarily would have to pay substantially
  higher premiums.
- 213. Two examples of this are worth mentioning. The first is the privilege given to all those holding a Physicians' Services Incorporated contract to carry it indefinitely at the standard rate regardless of age or condition of health. This has meant that all those leaving a group for any reason, including superannuation, have been able to continue protection if they so desired. The second, the ability to enrol, at the one rate all people in a municipality (so far Orangeville, Markdale and Lindsay) who wish to purchase P. S. I. (during a group opening for that municipality), again regardless of age or condition of health.
- These two approaches have meant a gradual reduction in the number of those unable to insure themselves because of age or condition of health. The fact that fifteen other municipalities, including two townships, have asked for a community plan is indicative of the interest in this program.
- 215. We would not suggest that all questions about pre-payment of medical services have been answered by P. S. I. because we know they have not. We are of the opinion, however, that the evolution of

satisfactory methods has been furthered by this co-operation of the profession and the assumption of personal responsibility by the people.

#### Indemnity Plans

- 216. Indemnity is insurance in the true sense of the word in that it indemnifies the subscriber against the monetary loss occasioned by the happening of a specified event in this case the receipt of medical care.
- 217. There is thus one distinct difference between service and indemnity plans. The true service plan can guarantee the subscriber that his physician's account for those services stipulated in the agreement will be satisfied by the payment made by the plan provided he seeks such services from a participating physician; the indemnity plan, on the other hand, provides up to a stated sum of money on behalf of each item of service specified in the policy but cannot guarantee that the amount paid the subscriber will satisfy the account rendered by any physician.
- 218. Indemnity insurance has more flexibility than service coverage because of the ease with which the amount insured on behalf of each item of service can be modified and the number of items covered can be expanded or contracted to meet the specific need of the subscriber or, more usually, to meet the amount of money available to pay the premium.
- One additional feature has characterized the indemnity plans in our province and that is the use of experience rating by group and by class of individual. By the employment of this mechanism each

group or individual is charged a premium rate which reflects the cost experience of that group or class of individuals.

- 220. These two factors flexibility of contract and experience rating have enabled the purveyors of indemnity insurance to maintain a
  competitive position with service plans.
- 221. The development of improved plans for protection against the cost of hospital and medical services has led to a demand for more protection against the cost of other health services.
- It has been interesting to watch the development of plans to meet this demand in our private enterprize environment. The dental profession has initiated a post-payment plan and in addition, has entered into an agreement with the Department of Public Welfare to provide dental services to indigent children on a basis similar to the Medical Welfare Plan; the pharmacists have approved a plan which pays the major portion of prescription drug costs and are developing plans at the municipal level to provide prescription drugs to welfare groups; the indemnity plans have broadened their coverage through policies usually called major medical or comprehensive and the service plans have added coverage of ancillary services through policies of extended health benefits.
- In order to give protection against costs arising in as broad an area of health services as possible, and at the same time keep the premium at a reasonable level, major medical and extended health benefit policies are written on an indemnity basis and with deductible and co-insurance features.

- Major medical policies have many variations. Some apply deductibles and co-insurance against all physicians' and ancillary services, others exclude some or all of the physicians' services from these provisions.
- Deductibles and co-insurance reduce the risk and thus the premium.

  In addition to the absolute reduction of risk due to the terms of the contract, there is a further reduction due to the deterrent effect on excessive utilization.
- Our service plans cover physicians' services in their regular service plans and apply deductibles and co-insurance in the extended health provisions for other health services.
- It may be argued that participating physicians through this type of arrangement by their service plans, are being paid their total medical account for the services covered by the agreement, while the services rendered by the providers of other health services are only partially covered. In a way this is true, but it should be remembered that the participating physician's allowed account is subject to the pro-ration required to keep the plan financially sound; furthermore, physicians should not be expected to guarantee the cost of services they do not provide.
- These newer plans have not been in operation for a sufficient length of time to allow us to form definite conclusions about them. The advantages would appear to be breadth of coverage and relatively low premium; the disadvantage, that the deterrent and co-insurance fall entirely on the subscriber with any employer contribution being toward the cost of the relatively low premium. This works more

hardship on the lower income groups than when the employer shares in the relatively high cost of the premium required for first dollar coverage.

- For this reason the trend might well be in the direction taken by the service plans where first dollar coverage is provided for the relatively expensive physicians' services element (now that hospital expenses are covered under the government plan) and the ancillary services only come under the deductible and co-insurance provisions.
- We have tried to set out as clearly as possible the basic difference between service and indemnity plans. While the differences are real, the effects on the subscriber are being modified in our province by a number of circumstances.

#### The Prepaid Hospital and Medical Services Act

- 231. The Prepaid Hospital and Medical Services Act was passed to supervise and regulate the activities of non-profit plans in the hospital and medical fields. The Act, as interpreted to us by the Superintendent of Insurance, allows all non-profit plans which pay the majority of accounts directly to physicians, to operate under the Act.
- 232. This direct payment to physicians, by plans which have no participating physicians' agreements, has tended to minimize the difference between service and indemnity contracts. This has been true particularly when the payments made have approximated the physician's ordinary fee, so that instead of billing the patient for minor differences, he as accepted it as account in full.

- 233. For the first time in its history, our Association has approved, effective January 1, 1962, a differential fee schedule whereby a scale of fees is set down for work done by general practitioners and a scale of fees for work done by specialists within their specialty.
- 234. This is bound to influence insuring agencies in our province because they will be able to establish, with more accuracy, scales of benefits which will satisfy the vast majority of both general practitioners' and specialists' accounts. The net effect is likely to be that indemnity insurance benefits will become as satisfactory to both physicians and subscribers as the benefits of a service plan with participating physicians' agreements, particularly if our Association can give the public reasonable assurance that the fees charged for the vast majority of medical services will not exceed those listed in the O. M. A. fee schedule.
- 235. We have reached a stage in our province where the majority of our citizens have insured themselves against all or part of the cost of medical services 63% against surgical costs, and 59% against medical.\* This means that expansion of business will soon depend upon ability to insure that segment of the population which heretofore has been left uninsured or incompletely insured because:
  - a) some were not part of a group
  - some were classed as uninsurable because of chronic illness
     or age
  - c) some were economically unable to pay the premium.

<sup>\*</sup>Source: Canadian Conference on Health Care (1961)

- 236. We have noted steps being taken by service plans to provide coverage for those able to pay the premium through community enrolment, and the approach being made to government by the Association to assist those unable to pay their own premiums.
- By and large, indemnity companies have not been active in this field because by experience rating less costly groups they have had to charge the appropriate premium to high cost groups and individuals and this rate has been prohibitive for anything approaching a reasonable degree of comprehensiveness.
- At the present time the Canadian Health Insurance Association is developing a mechanism whereby it hopes to overcome this handicap.

  Our Association, being interested in seeing that insurance for the cost of medical services is available to all on a voluntary basis, appreciates the positive approach now being taken. We understand that the proposals of the Canadian Health Insurance Association will be submitted at this hearing of the Commission.
- It is apparent that in our province we have a great variety of insurance mechanisms as they apply to the cost of personal health services. At the present time there are nearly forty non-profit plans operating under the Prepaid Hospital and Medical Services

  Act; there are many plans underwritten by indemnity companies, some of which are stock companies and some mutual in addition, there are a number of plans which limit coverage to a class of citizen or a type of illness.
- Our Association feels that very rapid progress is being made toward the goal of universal availability by methods which ensure a large

measure of free choice to both the provider and receiver of services.

Moreover, our Association is of the opinion that the history of
medical insurance is so short in our province that the evolutionary
process is far from complete. We believe that in this situation more
rapid progress will be made and a more satisfactory result achieved
if the stimulation of friendly competition by multiple carriers is
allowed to continue.

#### RESEARCH

- The private practitioner is interested in research because out of it comes new drugs, new diagnostic aids, and new therapeutic techniques which give him renewed confidence and his patients renewed hope. His desire is to cure wherever possible and he knows from experience that cure so often depends upon specificity of therapy and specificity is born of research.
- There are two kinds of research, one, fundamental or basic scientific research, which is usually carried out in settings where men with special training have facilities suitable for their needs; the other, clinical observation, which is carried out by trial and treatment and observation by every physician who has responsibility for the care of patients.
- 243. The private practitioner is evaluating new drugs, procedures and techniques every day. Drugs, for example, come and go but those which remain are those the private practitioner has found to be effective; new procedures are developed, written up, publicized, but the private practitioner who lives with the result is often in the best position to give a true evaluation.

- The Ontario Medical Association, having observed the changes brought about by insulin, penicillin, and open heart surgery, to name but a few, is aware of the need for an accelerated program of medical research.
- We believe that medical research should be supported by funds
  designated for that purpose and administered through an agency such
  as the Medical Research Council; that workers in fundamental
  research should not have to support themselves by teaching and/or
  practice; that research funds should not be used primarily to
  support teaching but only when it is in the interest of the research
  worker and the project, as well as the student; that facilities, space
  and assistants are necessary adjuncts to any research program;
  that there must be a continuity of grant to avoid frustration and
  waste; and that remuneration and working conditions must be such
  as to attract and keep trained research workers.

#### PRIORITIES

- We have attempted to portray the development of health services and health services' insurance in our province. We have pointed out the evolutionary nature of this growth and our belief that reasonable progress has been made year after year.
- We are of the opinion that, in the natural course of events, progress will continue to be made in all areas. We believe it would be unwise to divert an undue amount of our resources to any one aspect, to the exclusion of others.

248. Within this framework, we would give priority to the recommendations made for improvement in the management of mental illness, the provision of adequate health services facilities and the recruitment and education of sufficient personnel for all health services.

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## THE ONTARIO MEDICAL ASSOCIATION SECTION ON INDUSTRIAL MEDICINE

- 1. The Canadian economy is undergoing unprecedent industrialization, so that in years to come occupational medicine will play an increasingly important role in maintaining and improving the health of the working population. Occupational medicine provides an ideal setting in which there is adequate opportunity to apply preventive health programs to adult Canadians. Improvements in therapeutic medicine have been so spectacular in the past quarter-century that more emphasis should now be given by the medical profession to preventive medicine.
- 2. In Canada at the present time, there are about 120 physicians employed full-time at occupational medicine. In addition, it is estimated that there may be 1,000 or more practising physicians who have a part-time affiliation with industry.

  Some 1,400 nurses are employed full-time by industries across Canada. About 80% of the physicians and nurses are employed in the heavily industrialized provinces of Ontario and Quebec.
- 3. As of March 1961 there were 64 full-time and 306 part-time industrial physicians. There were also more than 700 full and part-time industrial nurses, and all these together covered some 500 manufacturing and non-manufacturing industries.
- 4. The cost of occupational health services in Canada is borne entirely by the industries concerned. Costs vary greatly with the nature, size, and location of the industry as well as the type and extent of medical services provided. Costs per employee vary from a minimum of \$5. to \$8. per year to a maximum of \$35. to \$40. Enlightened modern industrialists

are convinced of the value of occupational health services in maintaining and improving the health of their employees, who are their most valuable asset. This contributes to increased efficiency and productivity, improved morale, and reduced costs from absenteeism due to illness and injury.

- 5. Occupational health services provide a valuable link between the practising physician and his employee-patient, in respect to the working environment, hazards of occupation, technical and medical interpretation, rehabilitation, and other factors affecting his welfare. (See Canadian Medical Association booklet, "Guiding Principles for the Provision of Occupational Health Services," attached as Appendix A.)
- Occupational physicians have been instrumental in influencing industries to provide prepaid health insurance plans and sickness benefits for employees and to improve previously existing plans.

#### 7. RECOMMENDATIONS

- A) That occupational medicine be recognized by the Royal Commission as an essential medical service in providing preventive health maintenance to a large and important segment of the adult population of Canada.
- B) That the medical profession and Canadian industry should be urged to promote and extend the benefits of occupational health services to the working population throughout the nation.

- C) That Canadian university medical schools should place more emphasis on the teaching of preventive medicine including occupational medicine.
- D) That more facilities be provided for the training of occupational health nurses, industrial hygienists, medical attendants, and technicians in the specialized field of occupational health.
- E) That research into occupational hazards and industrial hygiene be promoted in order to ensure a healthy working environment for Canadians.

REPORT - CONFERENCE ON REHABILITATION SPONSORED BY THE ONTARIO MEDICAL ASSOCIATION MARCH 2nd. 1962

- 1. The Committee on Rehabilitation of the Ontario Medical

  Association was concerned about the lack of co-ordination of the

  many services and personnel involved in the field of rehabilitation.

  With the approval of the Board of Directors of the Ontario Medical

  Association and the assurance of responsible persons in this

  broad field that no conflict of interest would result, a Conference

  on Rehabilitation was sponsored by the Association under the

  guidance of this committee.
- 2. The conference was held in the Park Plaza Hotel, Toronto, on
  Friday, March 2nd, 1962, and representatives were invited from
  voluntary health organizations, allied professions, para-medical
  groups, rehabilitation centres, departments of government
  (health, welfare and education), university teaching departments
  and employers.
- 3. Prior to the conference, a questionnaire was distributed to all organizations invited, and the replies were of considerable assistance to the O.M.A. committee in outlining areas where problems were reducing the effectiveness of specific programs.

  In addition, the replies provided constructive suggestions for the medical profession to assist others in the provision of rehabilitation services.
- 4. The purpose of the conference was to assist doctors in the field of medical rehabilitation but, more important, to ascertain and to find solutions for, some of the problems that exist between the medical profession and the associated services, including government and volunteer agencies without whom a total rehabilitation program would be impossible.
- 5. Dr. R.H. McCreary, president of the Ontario Medical Assoc-

- iation, welcomed the visitors and outlined the views of the Association on the subject of rehabilitation. His address is presented later in this report.
- 6. The morning session consisted of a series of key papers which reviewed the present status of rehabilitation and provided recommendations to improve the co-ordination of the efforts of those concerned in the total care of the patient.
- 7. Dr. John Crawford, chairman of the O.M.A. Committee on Rehabilitation, was chairman of the morning session. The speakers were Dr. A.T. Jousse, medical director of Lyndhurst Lodge Hospital; Dr. R. Bruce Sloane, professor of psychiatry at Queen's University; Dr. J.E.F. Hastings, associate professor of public health and preventive medicine at the University of Toronto; Mr. Kenneth Hawkins, director of rehabilitation for the department of health, and Mr. John Amos, co-ordinator of vocational rehabilitation for the department of welfare.
- 8. During the luncheon, Dr. R.R. Mutrie discussed the questionnaire and the replies which had been provided through the co-operation of many organizations.
- involved in the care of the patient to present their problems and to suggest how the medical profession could assist in eliminating these difficulties. Mrs. Betty McMurray, executive secretary of the Rehabilitation Foundation for Poliomyelitics and the Orthopaedically Disabled, was chairman. The speakers were Mr. Leonard Coulson, regional director of the National Employment Service; Miss. Jean Sutherland, occupational therapist at the Toronto Rehabilitation Centre; Mr. H.H. Doyle, president of the Canadian Association of Prosthetists and Orthotists; Miss.

Helen Saarinen, physiotherapist at Queensway General Hospital;
Mrs. Margaret Reid, department of social service, Toronto
General Hospital; and Mrs. Lorna Kruger, director of the
Toronto Rehabilitation Centre.

10. A post-conference committee was appointed during the conference to meet subsequently and prepare a report on the meeting and to be responsible for recommendations which were initiated by the discussion or were required to complement the problems raised by the various speakers. As a result, the chairman and members of the afternoon program met with the O.M.A.

Committee on Rehabilitation to form this post-conference committee. The recommendations of this committee follow.

#### RECOMMENDATIONS

11.

These recommendations are the considered opinions of the group appointed at the conference. They are intended to represent the general views of all organizations represented at the conference and not necessarily any one organization.

- The committee recommends that the Government of Ontario appoint a provincial co-ordinator of rehabilitation with authority to direct government effort in this field;
- The committee recommends that there should be closer liaison between the government departments involved in rehabilitation, such as health, welfare, education and labour;
- 3. The committee recommends the establishment of rehabilitation councils at the community level to maintain a register of persons in the area who require rehabilitation services. These councils should support the building of rehabilitation centres, sheltered employment and workshop facilities, all of which require financial aid from public funds;
- 4. The Committee welcomes the interest of the Ontario

Department of Health in surveying the need at the community level, but it is recommended that the initiation and promotion of any local rehabilitation program should be a community effort combining the energies of all interested parties. The medical officer of health in the community should be available to assist a program of this nature.

- The committee recommends the development of sheltered employment and workshop facilities at a community level with assistance from public funds.
- 6. The committee believes that rehabilitation centres should be comprehensive and recommends the development of such centres on a regional basis supported by the communities served, with assistance from public funds.
- The committee recommends that the medical director of a rehabilitation centre should be qualified in physical medicine.
- 8. The committee warns that there is a marked shortage of professional and technical personnel associated with rehabilitation programs. This is a serious problem for present requirements and undoubtedly would slow up future expansion of an adequate province-wide program. Therefore, the committee recommends better financial return to attract individuals into this service and the provision of adequate under-graduate and post-graduate training facilities.
- The committee recommends that government departments consider the possibility of additional training grants to assist in the alleviation of this shortage.
- 10. The committee recommends that the medical profession take more responsibility for the para-medical groups; specifically their training programs, the provision for post-graduate training and their working conditions.

- 11. The committee recognizes the value of the conference and recommends that the O.M.A. Committee on Rehabilitation convene a similar conference at least once annually, to provide a forum for discussion of mutual problems and for liaison between medical and para-medical groups.
- 12. The committee recommends that medical education should include teaching and training in physical medicine and rehabilitation for medical students and interns, to make them more aware of the services rendered by the para-medical groups. This should include training in the proper method of early referral and prescribing for treatment services.
- 13. The committee recommends that the medical profession receive more training in the application and availability of prosthetic appliances. This might include an invitation to makers of limbs and braces to attend annual clinical meetings with orthopaedic surgeons, therapists and other physicians in order to make each group aware of facilities.
- 14. The committee recommends that the makers of limbs and braces be encouraged in their efforts to provide the best products in the field. As long as they provide service and have top-grade material they can successfully challenge the increasing competition from similar government services.

  The limb and brace makers were asked to consider the feasibility of undertaking more extensive research leading to the development of more efficient braces and artificial legs, so that this country could become a leader in this field. Government funds should be made available for this research.
- 15. The committee recommends that payment for qualified and adequately supervised rehabilitation services be included

- in health insurance programs.
- 16. The committee recommends a concentrated effort in public education to achieve an understanding of the need and purpose of rehabilitation of persons suffering physical and mental disabilities.
- 12. Opening Remarks by R. H. McCreary, M. D., President, Ontario Medical Association
  - "A few months ago, at Niagara Falls, I had the pleasure of meeting a group such as this at the Second Ontario Conference on Handicapped Children. As most of you know, this was a highly-successful conference from which came a number of important resolutions that are now receiving study with a view to implementation.
- One of the conclusions of the conference was that there is a need for the establishment of more hospital and community rehabilitation centres andworkshop facilities for the handicapped child.
- 14. Your conference here today is concerned with the broad field of rehabilitation, but seems to me to be a natural follow-up to the study of the problems of the handicapped child.
- 15. The views of the medical profession on the subject of Rehabilitation

  are summed up in a statement adopted by the Canadian Medical

  Association in 1955:
  - Rehabilitation may be defined as the restoration of the handicapped individual to the fullest physical, mental, social and economic independence compatible with his or her disability and remaining talent and ability. Since disabilities tend to show an increasing incidence in the later decades of life, and since the span of life is continuing to increase with more and more people living to this older age, the expanding need for rehabilitation services is obvious. In many cases the restoration to useful function

will be well handled by the private physician. Other patients will require in addition to doctor and nurses the services of physical and occupational therapists, social workers, psychologists, educationalists, vocational counsellors and others. Rehabilitation is an integral part of the total care of the patient and is of equal importance with prevention, diagnosis and definitive treatment. For these reasons The Canadian Medical Association desires to record its current views on this important matter.

- 2) It is recognized that primary responsibility for the institution and direction of rehabilitation procedures is a medical one, but that the services of many auxiliary workers may be necessary to achieve full restoration of some persons. The integration of the efforts of all concerned with the restoration of the patient is essential. We recognize that it is the person who requires rehabilitation, not his disease. His own attitude towards recovery is an important element and a favourable attitude should be fostered from the outset.
- 3) In every Canadian community there should be available the resources of physical medicine and rehabilitation. In many instances these facilities should be in a department of a general hospital; in others the rehabilitation centre may be provided under other auspices. There already exist in many communities services which have been established for special purposes and where these are present their co-ordination and elaboration is essential.
- 4) To prepare the profession to assume its primary responsibility, doctors require education in the total process of rehabilitation. Such training as is necessary must be forth-

coming from the medical schools, and to this end there should be developed rehabilitation units in teaching hospitals or in separate rehabilitation centres, whereby the members of the profession will acquire the necessary skills. This must include integration of the efforts of the various auxiliary workers who are rightfully members of the team. These clinical centres will serve to indoctrinate students and will provide physicians and surgeons, nurses, psychologists, social workers, vocational counsellors, educationalists and others with the necessary competence, through experience and training. These expert professional workers will thus become available to staff the rehabilitation units in hospitals or other centres which must develop in every community in order that the rehabilitation needs of our citizens may be met. They also will be able to focus public interest on the need for, and the availability of, rehabilitative services in their respective areas.

- 5) The provision of training centres at the teaching hospitals of Canadian medical schools has since 1951 been repeatedly put forward as the essential undertaking. The Canadian Medical Association would endorse the establishment of such centres and urge that their provision be given immediate priority.
- f) It is appreciated that economic factors have impeded the provision of such facilities and services but in many instances the public funds which are now available have not been utilized. However, economy in the use of active treatment beds has been demonstrated and an over-all saving to the community is achieved through reduction of invalidism and the elimination of expenditures for pension

and relief.

- 7) A realistic appraisal of the problems of rehabilitating
  people reveals that there are on the one hand those who do
  not require any special assistance, a larger group who
  would benefit from the services, and a further group who
  in the present state of our knowledge are beyond the
  resources of rehabilitation.
- 8) For this latter group of patients who cannot profit by the rehabilitative services, it is necessary to provide facilities for their care and comfort separate from rehabilitation centres. For such persons who are permanently and totally disabled and therefore pensionable, the profession must assume its responsibility for their identification and continuing welfare, but we recommend that accommodation for such persons be provided separately from the active rehabilitation centres.
- 9) The establishment of divisional committees on rehabilitation provides the opportunity for the expression of the medical viewpoint in this important matter. It is recommended that, with variations designed to fit local conditions, the principles here outlined be applied in every community in co-operation with the official agencies of the provincial departments of health, welfare and of the municipalities and voluntary agencies.
- 16. Last year the Canadian Medical Association asked its 10 divisions

   the Ontario Medical Association in this province to inform

  provincial governments of the medical profession's concern over

  the shortage of personnel in the field of rehabilitation, and to

  urge the provinces to encourage the training of para-medical

  personnel in co-operation with medical societies and universities.

- 17. With this background, and with knowledge of some of the problems in the rehabilitation program, the O.M.A. Committee on Rehabilitation recommended the calling of this conference.
- It is obvious there are more and more agencies becoming involved in the field of rehabilitation every year, and each of these agencies is supported by dedicated people, most of them volunteer workers. This is an encouraging trend that should be welcomed and fostered. However, we must be careful that in our desire to cover the entire field of rehabilitation services we do not overlap in some areas and leave others begging assistance.
- 19. The main reason for calling this conference is to determine whether there is a need for a central agency to co-ordinate the efforts of the many organizations and individuals involved. We ask that you ponder this question during today's deliberations, and further that you offer some suggestions regarding the organization of such an agency. If a co-ordinating council is necessary and desirable, who should assume responsibility for organizing and maintaining it?
- 20. It is my pleasure to welcome you to this conference. I hope you will make it worthwhile through thorough and frank discussion of the problems as they exist today and through constructive suggestions as to their solution. In this way we will be helping to make safer, surer and quicker the handicapped person's return to society."
- Keynote Address by Dr. A.T. Jousse The Role of the Medical Profession in a Rehabilitation Program for the Physically and Mentally Disabled.

The goal of the physician or surgeon or psychiatrist engaged in the treatment of persons suffering from disease or the results of trauma is to achieve elimination of the disorder and the restoration of the patient to a functional whole. A simple formula has been

evolved which is applied in each instance, but not invariably are the results those which are most desired by the patient and the doctor. Where failure ensues and the patient is not relieved, the necessity for prolonged management and care of the patient arises, and it is during this chronic phase that the need arises for rehabilitation services as conventionally understood.

- 22. The formula applied by the medical profession is simple of concept but often difficult of execution. It consists of four steps. The first is <u>precise diagnosis</u>, which may be achieved by clinical examination and history-taking alone. Frequently, however, detailed study by means of special techniques is required, and these measures are sometimes trying for the patient and are frequently expensive in time and money.
- 23. Precise diagnosis is a sine qua non for the application of the second step, which is specific therapy, whether it be curative or palliative. When the therapy is curative, active treatment usually ends in a period of convalescence followed by restoration of the patient to his pre-illness level of performance. In effect, he has been rehabilitated by the removal of the cause of his illness or injury. In practice he is not considered to be in need of rehabilitation.
- Where the treatment is palliative or perhaps ineffectual, the patient is left with a persisting disability. This leads to the third measure of medical care, namely, evaluation.
- The objective of evaluation is to determine the extent of impairment of function. It is not sufficient to note the loss suffered by the patient as for example the paralysis of a lower extremity but rather to relate the deficit to impairment of function in this case, impairment of the function of walking. Beyond this, the physician should also interpret what impaired locomotion may mean to the patient in relationship to his daily living and his vocational

potential.

- In many instances the experienced medical person successfully encourages and counsels the afflicted patient so that he is able to get going and deal with his disability without great difficulty and without enduring prolonged interruption of his normal living pattern. This is so for both major and minor disabilities, and is dependent not so much on the extent of the disability and its severity, as on the calibre of the man or woman who suffers disablement and, to a lesser extent, on the wisdom and understanding of the doctor.
- 27. It is of the utmost importance that every doctor charged with the care of a patient as he suffers disablement, put forth a supreme effort to complete the task of re-establishing the patient at this point, for the great majority can be successfully dealt with at this level, and the number of derelicts may thus be reduced to a minimum. The general practitioner as well as the specialist may achieve much success in this fashion in the management of the chronically sick. In practice, much successful rehabilitation has been and is being carried out by members of the medical profession at this level. With little extra effort and with greater facilities, much more could be achieved. This will be particularly true when the para-medical personnel become available in each community. The practising doctor will then be able to refer patients readily to the appropriate community facilities, at the most appropriate time in the course of the patient's illness. While it is true that many doctors do not avail themselves of the existing facilities and must be educated on this point, it is also true that existing facilities should be made much more readily accessible to the members of the medical profession.
- 28. For those with persisting physical and emotional disorders, often

a program of restorative treatment is necessary. This is the fourth step in management. It may include provision of prosthetic devices, restorative exercises, counselling and advice on how to adapt one's living to new and difficult circumstances. Particularly, the team should analyse the extent to which the disability determines the kind of employment the person may accept.

- Where a restorative program must be undertaken, the patient will require the assistance of a variety of skilled persons. This supplementary assistance may take the form of the services of those specially trained in nursing care, physical and occupational therapy, psychology and social work, and also vocational counsellors, teachers and speech pathologists, limb and brace makers.
- 30. Special physical facilities are usually required to enable these ancillary personnel to practise their skills successfully. These special facilities constitute rehabilitation units when staffed by the requisite trained workers.
- 31. Rehabilitation facilities should be located convenient to the sites

  where sick and disabled persons assemble to ensure availability

  of investigation and active care that is, in or near hospitals.
- 32. The physical requirements may be represented as follows:
  - l) Rehabilitation units in university centres,
    - (a) Teaching general hospitals,
    - (b) Special rehabilitation centres;
  - 2) Rehabilitation units in large general hospitals (non-teaching);
  - Rehabilitation units in smaller hospitals;
  - 4) Rehabilitation units for special disabilities;
  - Rehabilitation units for children for special care, including emotional problems.
- 33. Rehabilitation Units in University Teaching General Hospitals.

  These should provide facilities for treatment, research and

teaching. The teaching, to be effective, must be directed not only to medical students and medical graduates, but also should include the training of physical and occupational therapists, rehabilitation nurses, speech pathologists and audiologists. psychologists, social workers, rehabilitation counsellors, orthotists and prosthetists. (Much of the teaching should be designed to acquaint the various disciplines with the purpose and function of the other disciplines concerned with restoration of the disabled.) In other words, the doctor in charge of the case must learn how to initiate activity on the part of the therapists, social workers and psychologists, and they in turn must know the role of the doctor and be given some understanding of his responsibility for the care of the patient. Research must, of course, be a prominent feature of the program in such a teaching centre. In addition to the rehabilitation units in the teaching general hospital, one might well require, in close proximity to these hospitals and within its organization framework, facilities which may continue the treatment program on either an in-patient or out-patient basis. Where prolonged hospitalization will be required, lower-cost hospital beds should be provided, still within the framework of the university and close to general hospital convalescent care.

#### The Special Rehabilitation Centre

34.

35. This is designed to deal with the problems of the long-term patients: those severely disabled and the geriatric problems who may benefit from rehabilitation.

#### The Rehabilitation Unit in the Large General Hospital

36. Outside of a university centre there would be less emphasis on teaching and research. These might well be established on a geographical basis throughout the province in accordance with the density of the population. This type of unit should render service to the patients of both the specialist and the general practitioner and must provide a comprehensive rehabilitation program.

- The Rehabilitation Units in the Small Hospitals. While these may not be able to support comprehensive rehabilitation programs, they would nonetheless play a very useful role. Physical and occupational therapists should be employed in such a setting and the services of the psychiatrist, the speech pathologist, the social worker and the psychologist must be made available on request.
- Rehabilitation for Special Disabilities. This category includes disabilities arising from involvement of the special senses and the central nervous system. Where present methods of treatment are not effective, rehabilitation units are essential in order that the best results may be achieved or the most effective research conducted.
- 39. The Requirements of Children. These are best met in units set apart from those which treat adults.
- with these facilities established and staffed with the appropriate personnel, the problem of rehabilitation of the disabled will be met insofar as present skills and knowledge serve to cope adequately with the problems of the incapacitated. It should always be borne in mind, however, that with our present limitations there are a great many people who cannot be restored to useful living, or indeed cannot be improved significantly through existing measures of rehabilitation treatment. It is an exercise in futility to apply treatment measures effective in one group to some other groups which do not respond to this form of treatment. Indeed, for those people for whom rehabilitation measures are at present ineffectual or non-existent, the need is met not by placing

them in a rehabilitation centre, but rather by conducting research programs aimed at evolving effective measures of treatment. This is true in a great many areas and applies to many of those of advanced age who, having disabilities and having lost their motivation, are beyond assistance at present. Others with chronically progressive disease conditions or who have suffered injuries which are so severe as to render them incapable of mastering useful living, may likewise fall into this area.

- Thus, rehabilitation services as rendered by the medical profession require the full co-operation of the members of the profession, the assistance of skilled and devoted para-medical professional workers, and certain physical facilities to focus the efforts of these various persons on the patient and his problem,
- 42. The address by Dr. Bruce Sloane stressed two points: The first was that all disability should be seen as a result of stress and that this view of medical disability would make psychiatric and physical rehabilitation one and the same thing. Essentially the same facilities and staffing could thereby be used.
- our experiences in cases of rehabilitation, should be attacked
  by appealing to the economic largesse of the whole. Psychiatry
  would be somewhat dominant in this situation but its appeal should
  remain unemotional.
- 44. Dr. Sloane reported on a survey of 600 cases in a large general hospital and it was concluded that rehabilitation problems involving mental illness do not need to be separated from other areas of rehabilitation.
- 45. <u>Summary of address by Dr. J.E.F. Hastings</u>: Dr. Hastings stressed the older and middle-age groups requiring rehabilitation.
- 46. Rehabilitation functions should be changed as follows:

- l) Research From past tense mortality statistics to present tense morbidity statistics to future specific statistics as to the nature and extent of disability. The M.O.H. is in a particularly advantageous position. All programs would be furthered by better communication.
- 2) <u>Planning</u> Committees should be local, sub-divided only for function; petty rivalries have to be foregone.
- 3) Action We must (a) find cases correctly;
  - (b) educate the public;
  - (c) consult and co-ordinate;
  - (d) the M.O.H. should occasionally be directly involved in primary action.
- 4) Evaluation.
- 47. <u>Conclusion</u>: A complex inter-related group effort is needed, using all existing social councils with intelligent leadership.
- 48. <u>Summary of address by Mr. Kenneth Hawkins</u>: Requests by agencies for variety of assistance over and above that supplied by vocational rehabilitation resulted in formation of Division of Rehabilitation Services within Ontario Department of Health in 1960.
- 49. The necessity due to awakening of communities to need for service by:
  - l) Awareness of needs of handicapped;
  - 2) Search for direction in leadership:
  - 3) Realization one agency could not provide all the services.
- 50. Result of this development:
  - Encouraged to form rehabilitation councils. Five have been formed.
  - 2) Public education for acceptance of handicapped;
  - 3) Future projects: (a) Provision of manual;
    - (b) Research and survey such as Oshawa experiment;
    - (c) Financial aid to centres:
    - (d) Answers to rehabilitation requests.

- 51. Problems:
  - disabled persons' attitude toward agency or person supplying rehabilitation;
  - bringing the disabled into conference technique.
- 52. Disabled want to be sure there is:

Co-operation of effort; Consolidation of effort; Unity of plan and goal with singleness of purpose; To have those working on his behalf to recognize and allow him to know the goal and his part in reaching it.

other personnel and their opinion should be respected in
working out a plan. In turn, the group of para-medical
personnel should be well qualified and able to contribute
positively to establishment of plan and goal.

All need warmth, sincerity and dedication.

54. Summary of address by Mr. John Amos:

The federal-provincial program is based upon a team process and is not the exclusive jurisdication of any one profession. A distinction is drawn between fields of service and "rehabilitation". In Ontario a distinction is made between medical rehabilitation in the health department and vocational rehabilitation program in the welfare department. Theoretically there is inter-departmental liaison but this is not regularized or systematized in Ontario. Rehabilitation is an "idea", a philosophic concept, and is not the exclusive field of a monolithic department or organization which controls all rehabilitation.

Progress has been made in Ontario in case-finding, assessment and training aspects of vocational rehabilitation. The program has been based upon co-operative arrangements between rehabilitation staff of the department of welfare and a host of voluntary and public organizations.

#### 56. Problems are:

- mentally retarded persons with less than 70 I,Q, who don't get jobs;
- 2) mentally ill people who complete a training course and need a higher level of preparedness at pre-vocational level;
- 3) a staff shortage;
- lack of special provisions for the purchase of physical restoration services.
- 57. Under the new Vocational Rehabilitation of Disabled Persons Act,
  we can look forward to the development of a comprehensive program for which the federal government will be prepared to share
  the cost not only of vocational assessment and training, but also
  medical assessment and treatment.

#### 58. Summary of address by Mr. Leonard Coulson:

- I) Co-ordination of rehabilitation services is essential.
- 2) Individual needs of handicapped should be properly planmed for so that social re-entry and employment re-entry will be in his best interests.
- 3) Planning must be:
  - a) Realistic:
  - Early-using N.E.S. in an advisory capacity not the end of this line. Also it should not be terminated in middle of his planned program;
  - c) Attention to patient's needs rather than his superficial desires. Do not support medically the whim of a patient and his desires but work out with employment officer a realistic future.
- 4) A medical certificate should:
  - a) Represent need;
  - b) Be in language the officer can readily interpret:
  - c) Assist in analysis of abilities;
  - d) Not attempt to appraise and fit into job without consultation.

### 59. Summary of address by Miss. Jean Sutherland:

Success in rehabilitation depends on:

I) Motivation of the patient;

- 2) Severity of the handicap or disability;
- 3) Efficiency of the rehabilitation team;
- 60. Criticisms of physicians' support:
  - They have not sufficient knowledge of occupational therapy to intelligently prescribe the treatment required for their patient. His prescription should request one or more of the following:
    - Therapy to develop certain muscle groups, etc., with a view to promoting functional return;
    - Instruction in activities of daily living (a.d.1.) and self-help aids;
    - c) Appraisal of work pattern or to develop work tolerance;
    - d) Program to promote pyschological adjustment in group socialization promoting concentration and motivation.
  - 2) They lack a willingness to follow up and supervise therapy;
  - Failure to interpret to his patient the aims and goals of theO.T., probably because of his lack of knowledge of same;
  - 4) Failure to maintain touch and contact with his patient.
- 61. Solution: A better training of the physician especially at the student and intern level in the available facilities for rehabilitation.

  Lecturing is not sufficient; they must have practical exposure to this field. Physicians require training in prescribing the therapy properly for the direction of the therapist.
- 62. Summary of address by Mr. H.H. Doyle: The main problem is:
  - The difficulty of the brace-maker and prosthetist-maker who
    is on a private enterprise basis having to compete with
    government service and government subsidy agencies;
  - When both federal and provincial monies are available for rehabilitation services in regard to restorative program, it seems that the brace-maker and prosthetist-maker should be entitled to fair remuneration similar to the other agencies in the field, from rehabilitation funds.
- 63. This speaker did not have a proposal for servicing patients in the more remote areas of this province other than by mail order.

However, he did suggest that if government and the Ontario
Workmen's Compensation Board cases were to be supplied by the
private brace and limb makers, he was certain there would be
sufficient to establish volume of work to competent branch brace
shops in remote areas of the province.

- 64. He recommended closer relationship between the orthotists, prosthetits and physicians, as part of the team.
- 65. Summary of address by Miss. Helen Saarinen:
  - 1) There is a need for post-graduate courses for rehabilitation personnel, including physiotherapists. For example, the amputee, cerebral palsy, P.N.F. techniques, etc. The O.M.A. can help by:
    - a) gaining co-operation of medical and hospital or centre administration staff in allowing time off;
    - b) sponsoring courses.
  - 2) Liaison between medical and para-medical organizations has value. Members of the O.M.A. might ask for representatives of medical and para-medical professional associations to meet once or twice a year on a continuing basis.
- Purpose: to provide a forum for discussion of problems of liaison,
   professional problems, etc.
- 67. Problems:
  - a) (i) Lack of facilities, e.g. waiting list in convalescent hospitals;
    - (ii) Misuse of therapists' time;
    - (iii) Need for courses for Canadian physiotherapists.
  - b) Lack of communication between doctor and therapist.
  - c) Lack of recognition as profession; the when, why and how of P.T. are not known by most doctors.
- 68. Recommendations:
  - Education of the medical profession to the use of physiotherapy in order to get early referrals, better diagnosis, complete prescriptions and direction with treatment;

- Canadian post-graduate courses for the whole rehabilitation treatment team;
- 3) A liaison between medical and para-medical associations;
- More active rehabilitation centres, staffed and equipped to treat all types of disabilities.

#### 69. Summary of address by Mrs. Margaret Reid:

- The family doctor should be more aware of the social services which are available to him on request;
- 2) The emphasis on the social service assistance in the field of rehabilitation is most valuable in assessment of the patient in his home situation, and secondly, on the motivation of the patient;
- 3) Communications should be improved between the medical profession and social service workers with regard to patients on a rehabilitation program. Particularly is this so in a large hospital or rehabilitation centre;
- 4) Consideration should be given to an intermediate station supplying rehabilitation service in long-term cases between hospitals and back-to-work situation.
- 5) The reminder that the social service worker is often the closest, and perhaps the most interested, person in the long-term cases of rehabilitation.

### 70. Summary of address by Mrs. Lorna Kruger:

A Rehabilitation Centre

Rehabilitation is a facility in which there is a concentration of services to provide a unified evaluation and rehabilitation service to disabled people.

- 71. A medical director of such a centre is aware of the following principles:
  - 1) The recognition of the importance of medical guidance.

- correlation and active participation of the medical profession in direct service to the handicapped;
- 2) The responsibility to interpret rehabilitation programs and services not only to his patients and the general public, but also to his fellow physicians;
- 3) A realization that the physician is a major factor in the success or failure of the rehabilitation process and that the ancillary services are depending upon him for concise direction and participation in planning.
- 72. The O. M. A. and similar organizations may assist the physician in fulfilling his obligation by:
  - a) Making sure that medical students are given a good working knowledge of rehabilitation so that when he becomes a physician he will prescribe intelligently;
  - By providing programs whereby practising physicians can become familiar with the rehabilitation process so they may be able to prescribe;
  - By informing practising physicians of the availability of rehabilitation facilities in their own community;
  - Encouraging physicians to participate on medical advisory councils and boards of rehabilitation agencies,
- 73. The physician should understand that a rehabilitation centre or service is not replacing but supplementing his services under his direction and guidance. He must appreciate his own importance as a member of the rehabilitation team. A centre is not a place to get rid of a difficult patient.
- 74. The centre is a realistic stepping stone from the hospital or severe illness, to normal community living.
- 75. For efficient rehabilitation, the rehabilitation team must be furnished with an adequate picture of the patient's disability,

- capacity and capability. The picture should include also a listing of vocational contra-indications or limitations, clues to emotional malfunction, work tolerance, etc.
- 76. In the past 10 years on an average, only 40% have been referred by physicians and the remaining 60% have been referred through health, welfare and social agencies.
- 77. Presumably, the community physician is not aware of the existence of rehabilitation facilities.
- 78. Co-operation by the physician with the rehabilitation team by reading their reports, and answering written requests for direction of his patient's program and occasionally finding time to encourage his patient and consult with the staff.

#### SURVEY OF GRADE 13 STUDENTS

#### 1. Analysis

Approximately 30,000 students write Grade 13 examinations each year in Ontario. Of these, it is estimated that fewer than 7,000 would obtain the necessary standing in the required subjects to qualify to enter medical school.

- 2. The survey indicates 53 of the total of 597 students surveyed
  (8.8%) indicated they intended to enter medical school. Total
  enrolment in first-year medicine during the 1961-62 term
  represented less than 6% of the total number who wrote Grade
  13 exams the previous year.
- 3. The 11 schools surveyed produced 53 students who plan to enter medical school; 31 of them from among the 193 students in three schools in university centres. These students represent only 32% of the total students in the survey, but they contribute 58% of the number who plan medical careers.
- 4. Largest Grade 13 surveyed was Port Arthur Collegiate, where only 10 of 140 students said they planned medical careers. Four of the 10 plan to enroll in the University of Manitoba, and the others will go to Toronto, Queen's and Western, some after one or two years at their local Lakehead College. Proximity to universities would seem to be a factor when these figures are compared with Prescott, for example, which is comparatively close to medical schools at Kingston, Ottawa and Montreal, and where four of 18 grade 13 students plan to enter medicine.
- 5. If the percentage of students interested in medicine in the three high schools in university centres were applied to all 11 schools in the survey, there would be 93 students contemplating

medical careers instead of 53.

- 6. Satisfactions of a medical career seem to attract most students, while the desire to help people generally and the sick in particular, also was a major factor. Only other reason mentioned frequently was the indefinable ambition to be a doctor, in some cases because of a doctor in the family or a family doctor who created a particularly favourable image.
- 7. Disregarding those who are not interested in medicine and those with other interests, the great majority of those who considered medicine seem to have been deterred by the high academic qualifications and the length of the medical course. This is somewhat related to financial considerations, which embraced not only the cost of attending university but also the years of internship and the cost of establishing a practice.
- 8. Difficulties, aside from financial ones, in getting established were one of the career hazards mentioned. Long hours of work and heavy personal responsibility discouraged others. A modern concept mentioned by several was the threat of some government-controlled medical care plan which would make doctors servants of the state.
- In counter-balance were statements by a few socialist-minded students who favoured state medicine.
- 10. Several students remarked on their lack of understanding of medicine, which they blamed partly on the doctors; a lack of encouragement which they blamed on the profession and guidance teachers. Some claimed they might have considered medicine if they had learned soon enough of the required subjects.

  Others protested the need for certain subjects, particularly

mathematics, in the medical course.

## 11. Why I decided to Enter Medical School

	London	Toronto (U.T.S.)	Riverdale	Goderich	New Toronto	Kapuskasing
Satisfaction (like sciences, research, rewards and prestige)	8	9			1	
Desire to help sick	7	6				1
Life ambition (always appealed; doctor in family, etc.)	8	2			1	
Serve public (ful-filling public need)	4	3				
Like people	4	1				
Other (family pressure, curiosity)	3	3				
Number of students reporting	18	13	0	0	1	1

	Port Arthur	Fenwick (2)	Tilsonburg	Prescott	Totals
Satisfaction (like sciences, research, rewards and prestige)	5	1	2	2	28
Desire to help sick	1		4	2	21
Life ambition (always appealed; doctor in family, etc.)	3	1		1	16
Serve public (ful- filling public need)	2	1	1	1	12
Like people	2	1		1	9
Other (family pressure, curiosity)	1				7
Number of students reporting	10	2	4	4	53

#### Why I Decided Not to Enter Medical School 12.

I	ondon	Toronto (U.T.S.)	Toronto Riverdale	Goderich	Kapuskasing	
Academic qualifications (course too long, too dif- icult; admission standards too high)	68	10	2	28	18	
Not interested in medicine	50	23	3	18	8	
Financial (costs too much; can't afford)	29	4	1	12	18	
Other interests	21	16	4	10	14	Ì
Hazards of career (socialism, long hours, responsibility, difficulty getting established)	11	13	1	6	9	
Personal qualifications (dislike of people, illness, blood, hospitals; lack of ability, etc.)	29	16	2	15	17	
Lack necessary subjects (not taking, or dislike, needed subjects, espec- ially math; uncertainty about medicine)	16	5	1	9	11	
Other (too old, enough doctors already, doctors too aloof; female)	12	5		3	3	
Number of students reporting	107	48	7	38	40	
	New Coronto	Port Arthur	Fenwick (2)	Tilsonburg	Prescott	Totals
Academic qualifications (course too long, too dif- ficult; admission standard	19 s	30	41	149	4	369
too high)  Not interested in medicine	19	74	34	31	5	265
Financial (costs too much can't afford)	14	22	28	34	2	164

	New Toronto	Port Arthur	Fenwick (2)	Tilsonburg	Prescott	Totals
Other interests	10	32	10	5	3	125
Hazards of career (socialism, long hours, responsibility, difficulty getting established)	3	6	9	76	2	136
Personal qualifications (dislike of people, illnes blood, hospitals; lack of ability, etc.)		13	4		4	106
Lack necessary subjects (not taking, or dislike, needed subjects, espec- ially math; uncertainty about medicine)	3	19	17		3	84
Other (too old, enough doctors already, doctors too aloof; female)	2	1	10	25		61
Number of students reporting	33	130	65.	62	14	564

# ONTARIO MEDICAL ASSOCIATION SECTION ON SALARIED PHYSICIANS

#### 1. RECOMMENDATIONS

THAT public medical services in the areas staffed by salaried physicians be improved so that adequate preventive treatment, reliable and complete diagnostic laboratory techniques, and adequate treatment for the mentally ill be made available.

- 2. THAT the present inadequate incomes of physicians in public service agencies be corrected in order to:
  - retain and attract sufficient physicians to provide improved services;
  - b) lessen the loss through emigration to higher-salaried posts in the United States, and so
  - c) reduce the output required of our medical schools to meet estimated needs.
- 3. A number of medical facilities in Ontario have been traditionally staffed by salaried physicians, specifically in such areas as public health, diagnostic and pathological laboratories, mental health and research. Such areas are, therefore, our chief concern. Vacancies exist at present in these salaried medical specialties in the public service in various jurisdictions in Ontario, to the extent of between 15% and 20% in public health.
- 4. A similar or higher percentage of vacancies also exists in the various diagnostic laboratories operated by the Ontario Department of Health as evidenced by the fact that only two of these laboratories are directed by a certificated medical specialist. The almost total absence of psychiatric out-patient facilities in many jurisdictions, except by token coverage by government

psychiatrists, is regrettable. The vacancies for well-qualified psychiatrists in the provincial mental hospitals and their out-patient facilities, probably runs as high as 40%. No mental hospital in our province has on its staff a qualified pathologist.

- 5. Vacancies such as these result in poor and inadequate services in the area of preventive medicine. Inadequate and/or unreliable diagnostic facilities for medical practitioners and smaller hospitals dependent upon such services, is the result.
- 6. The treatment area, as in mental health, reveals a wide range of neglect: from non-existent facilities in some jurisdictions, to custodial care, to insufficient treatment to relieve symptoms in other areas. Physicians employed in such areas become discouraged over their inability to provide good and adequate treatment, and resign.
- 7. It is recognized that in some areas in medicine, such as the foregoing, it is difficult to arrive at an equitable means of remuneration for services other than a salary basis. Applying a unit basis for physicians in laboratories, for example, would mean excessive bookkeeping and, it has been estimated, would bring remuneration to \$30,000. per year and up. Payment on a fee-for-service basis, as per the Ontario Medical Association fee schedule, has been worked out for a number of physicians in mental hospitals, and again the figure exceeded \$30,000. per annum.

- The remedy for the foregoing is to increase salaries, thereby attracting and retaining well-qualified specialists in these salaried areas.
- 9. The necessity of increasing the output of Canadian medical schools and opening new schools to provide medical manpower for the increasing Canadian population, has been variously recommended. The medical schools in Canada now are graduating approximately 850 physicians annually. The loss of Canadianborn medical graduates on immigrant status to the United States has been increasing steadily since 1953. Since 1957 this has represented 25% to 29% of the annual total of graduates. Breakdown figures as to specialty, salaried position or private practice, relating to physicians emigrating to the United States, are not available. There is ample evidence, however, to suggest that a high percentage of this loss is to salaried medical posts in the United States, and that the largest group is the psychiatric specialty. Many mental hospitals in the United States have more Canadian than American physicians on staff.
- The 1959 figures for licensed physicians in the Province of Ontario are as follows:

Ontario.

Fully licensed - Ontario	8,126
Non-resident	974
Resident	7,152
Income tax statistics "self-employed"	5,024 2,128
Estimated number of senior interns	200*
*Junior interns beginning in 1959 were ineligible for a full license in	THE PERSON NAMED IN COLUMN 1

- It therefore can be reasonably assumed that the remaining
   1,900 or more were "salaried physicians."
- 12. The taxation statistics issued by the Department of National

  Revenue for 1959 in Table I, for "self-employed physicians"

  only, for Ontario is as follows:

### TABLE I

ONTARIO:	Number of	Total Net	Average
	Physicians	Income	Net Income
	5.024	\$83 827 000	\$16 750

(These figures include retired and semi-retired "self-employed physicians.)

- 13. The figures relating to average income for salaried physicians is not available for the taxation statistics as salaried physicians, representing about 28% of all physicians, are included with other employed persons.
- 14. A survey of income of salaried physicians in Canada was made by the Canadian Medical Association in 1959. A questionnaire was sent to 2,600 salaried physicians. There were 1,605 replies but a number of these did not qualify by the definition of salaried physicians for inclusion in the survey, the results of which are tabled in Table II attached.
- The salary average of the 301 full-time physicians in the

  Ontario Department of Health as of April 1961 was \$9,511. gross,

  minus 6% deduction for superannuation fund, plus the fringe

  benefit of the government paying the equivalent of 6% of the

  individual's salary into the superannuation fund.

- The figures available indicate that the incomes of self-employed physicians in Ontario and the United States are roughly parallel, whereas the average income of salaried physicians is much higher in the United States than in Ontario. A survey by the American College of Surgeons published in the bulletin of that body in February, 1959, states: "In the ten-year period 1947-1956 the mean net income of salaried physicians increased by about 75% to \$14,000., as compared to a 60% increase to \$18,000. in the mean net income of self-employed physicians."
- 17. It therefore appears that the considerable discrepancy between the average incomes of salaried physicians and self-employed physicians is the main reason for physicians in the salaried group to seek employment in the United States.
- The following statistics indicate the loss of Canadian-born white graduates of Canadian medical schools to the United States. Accurate information is not available, but it is believed the majority migrate to pre-arranged salaried positions in the United States. The Dominion Bureau of Statistics publication, "The Canadian-born in the United States" (reference paper No. 71, 1956), estimates the Canadian-born white population of the United States in 1956 to be in excess of one million.
- The following table lists the total number of graduates from

  Canadian medical schools by year, and figures received

  from the Immigration and Naturalization Service of the United

  States Department of Justice showing the number of Canadian

  physicians admitted to the United States as immigrants by years:

20.	Year ending June 30	Total Graduates Can. Medical Schools	Physician Immigrants to United States	% in Relationship to Graduating Class
	1951	858	214	27%
	1952	783	184	23%
	1953	825	130	16%
	1954	896	116	13%
	1955	894	128	14%
	1956	816	151	18%
	1957	893	256	29%
	1958	828	218	26%
	1959	859	210	25%
	1960	863	245	28%
	1961	845		

- 21. The annual loss of Canadian-born and educated physicians to the United States as immigrants is therefore roughly the equivalent of the total annual graduating class of University of Toronto and McGill combined.
- The periodical, "Open Doors," published by the Institute of
  International Education, New York, lists the following
  (non-immigrant status:)

# Canadian Physicians Training in the United States Hospitals

1954-55	520
1955-56	584
1956-57	576
1957-58	535
1958-59	563
1959-60	539
1960-61	658

# 23. Existing Salaries for Physicians - Canada

Detailed information is not available but the following facts illustrate some of the highlights. Medical specialists in radiology, pathology, physical medicine, etc., employed by general hospitals in Ontario receive \$20,000. to \$25,000. salary plus private practice privileges. The Hospital Insurance Commission in Quebec approves a maximum of \$22,000. in public general hospitals.

- 24. The maximum published yearly scale for federal government medical specialists is \$16,500., but others unpublished outside of the scale exceed this figure. The Saskatchewan government scale, effective April, 1962, has a maximum of \$19,104. for superintendent of a mental hospital. The Ontario government's published maximum is now \$15,000., with the average salary for the 301 full-time physicians as of 1961 being \$9,511.
- 25. Salaried physicians in the United States receive salaries
  approximately 50% to 75% higher than Canadian salaried
  physicians. Much correspondence and interviews with Canadianeducated physicians in the United States indicate clearly that many
  prefer to return to Canada, but low salaries prevent them. This
  economic loss to Canada would be largely eliminated by
  improving Canadian salaries.

TABLE II

Salary Groupings, of Composite Groups of Respondents in Organizational and Administrative Categories

Salary groupings	All respondents in organizational and administrative categories	Public Health personnel-(M.O. H. & govern- mental admin- istrative and consultative categories	Others - (university, medical and hospital administration, occupational health, research and pharmaceutical manufacturing
Under \$6,000.	9	6	3
\$6,000\$9,000.	139	80	59
\$9,000\$12,000	305	155	150
\$12,000\$15,000	0. 137	48	89
\$15,000\$18,000	). 37	7	30
Over \$18,000.	20	5	15
Total	647	301	346
Average Salary <sup>1</sup>	\$11,003.	\$10,355.	\$11,566.

<sup>&</sup>lt;sup>1</sup>As salaries were reported in groups, averages must be considered approximations only.

By definition, respondents receive 90% or more of earned income from one salaried source.

## SECTION ON CLINICAL PATHOLOGY

- 1. The Section on Clinical Pathology of the Ontario Medical

  Association, having given due consideration to the opinions

  expressed by its members in numerous discussions and debates,
  and acting herewith through the medium of its duly elected

  executive body, respectfully submits, as follows:
- 2. The members of the Section on Clinical Pathology of the Ontario

  Medical Association, in common with members of similar

  provincial organizations throughout Canada, are, in accordance

  with all regulations which pertain to such matters, duly qual
  ified medical practitioners.
- 3. These same have further demonstrated, through examination, such specialized interests, training and skills as assures their inclusion within the category of medical specialists.
- 4. Therefore it is required of all agencies and administrative bodies that this status be accorded full recognition in all matters pertaining to professional activities, contracts, negotiations and the like.
- The opinions, recommendations and conclusions which are clearly and expressly delineated in the brief which has been prepared under the aegis of the Canadian Association of Pathologists for submission to the Royal Commission on Health Services are, in essence, those with which the Section on Clinical Pathology of the Ontario Medical Association are in agreement. Since, in this regard, no area of major disagreement would appear to exist between these sister

organizations, the Section on Clinical Pathology, O.M.A. wishes to record, herewith, its endorsement of the C.A.P. submission.

- 6. The practice of Pathology, when considered in relation to other medical specialties, is, for the most part, conducted in a uniquely close association with hospitals.
- 7. The progressive loss of his identity as a medical specialist which the practicing pathologist has suffered through this association is no less to be regretted than is the particularly vulnerable position which it imposes on the discipline of pathology in such future developments as may further reduce the autonomy of individual hospitals.
- 8. In this regard the Section on Clinical Pathology of the Ontario

  Medical Association is particularly desirous of expressing

  its agreement with the viewpoint represented in Dr. Glenn

  Sawyer's uniquely lucid editorial from which the following is

  directly excerpted.
- 9. "Most people don't seem to appreciate that once government becomes the sole purchaser of medical services it has achieved exactly the same position as if it had every doctor directly in its employ. Many doctors do not appreciate it either and spend all their time talking about fee-for-service, free choice, etc.
- 10. "Every proposal should be examined with this one thing in mind. If, in spite of allowing the doctor some of the things he wants such as fee-for-service, it ends up by making

government the sole purchaser of his services, then it is a plan that should be opposed.

- that we would support any plan which gave us the freedom to sell our services on the open market. Whether we sell them on a basis of salary or fee-for-service is a matter of personal choice. This is a point of view which might be appreciated by large segments of the public. The majority of our people would not like the government to be the sole purchaser of their services. Even the people who work for government now leave if they are unhappy and do the same type of work outside of government. Moreover, their wages and working conditions are influenced by what people doing the same type of work get for their services from other employers.
- 12. "Once a government purchases the total services of an occupational group, individual members cannot leave the group and continue their occupation. Thus there is no longer a group outside government to act as a catalyst.
- 13. "We should not be saying we do not want to be civil servants.

  This isn't fair to the excellent civil servants we have in our country and it isn't what we mean. What we should be saying is that we do not want to be compelled to be civil servants because government has made it impossible to do anything else. We want to have the freedom to choose our employer.

  Perhaps we could communicate better if we talked about our problem in terms readily understood by every workman."

- The participation of the C. A. P. in a number of areas which relate to the efficient practice of laboratory medicine (e.g. quality control, technician training) is approved and commended. The Section on Clinical Pathology of the O. M. A., being not unmindful of its duties and obligations in this regard, is hopeful that, when undertaken on a regional (i.e. provincial) basis, similar studies may prove to be both additionally instructive and somewhat easier of completion:
  - to this field may be properly assessed, and, further, that methods of implementation may be explored and evaluated, the Section has caused to be appointed a Committee on Quality Control. The activities of this committee, in conjunction with a continually expanding group of participating hospitals and institutions, has, to date, been productive of a number of illuminating reports, on the basis of which further progress in this field may be confidently anticipated.
  - 2) Being cognizant of their unique relationship to the rapidly expanding and increasingly more demanding field of medical laboratory technology, and, in acknowledgement of the part which it and companion organizations might reasonably be expected to play in the guidance, development and supervision of this critical area in the broad field of medical care, the Committee on Technician Training (Section on Clinical Pathology) is currently engaged in a province-wide survey, on the basis of which a considerable quantity

of pertinent information relating to this field, and not otherwise available, eventually will be placed at the disposal of interested agencies.

Medical Association, being fully receptive of the principle that the quality and standards of professional practice should, at all times, and in all areas, be of the highest possible order, declares itself to be committed to an equal degree to the principle that the determination, maintenance and continued improvement of such standards, lie most properly within the scope of activities of the particular professional group concerned, in this instance, the Section on Ciinical Pathology, Ontario Medical Association.

# ONTARIO MEDICAL ASSOCIATION SECTION ON OPHTHALMOLOGY

Provision of Ocular Care to the People of Ontario

1. Preamble: Adequate ophthalmic diagnosis and care can be carried out only by properly trained medical personnel.

Ophthalmological opinion to-day does not recognize any such isolated procedure as a refraction (or test for glasses); it must be a part of a careful, complete ophthalmic examination by an examiner well trained to discover early evidence of disease conditions and qualified to treat such conditions.

# Progress in the Provision of Ocular Care

- 2. In the past there have been insufficient numbers of adequately trained medical practitioners of ophthalmology. Prior to World War II, no adequate program of post-graduate training for such personnel was available in Ontario (or elsewhere in Canada.) Many Canadians who went to other countries for this special training did not return to Canada.
- 3. Since World War II, satisfactory post-graduate courses have been instituted in several of the universities in the province and these have been the main source of qualified specialists. The source is augmented slightly by immigration from other countries and by the return of a few Canadians trained elsewhere.
- 4. Unfortunately, the effectiveness of these courses is weakened by the following:
  - a) Because of the scarcity of training facilities in the other

    Canadian provinces, only about 50% of the trainees have been
    natives of Ontario and only these remain to practice here at
    the end of their training.

- Retirement, emigration and death of ophthalmologists already in practice.
- c) The population of the province has increased from 3.4 million in 1940 to 6.2 million in 1962.

## The Present Situation

- 5. In 1950, the Expert Committee on Professional and Technical

  Education of Medical and Auxiliary Personnel of the World Health

  Organization suggested that one eye, ear, nose and throat

  specialist be required for each 15,000 population. Since the modern

  trend is to separate ophthalmology from otolaryngology, we might

  suggest one of each specialty per 30,000 population. If the

  population of the province be taken as 6 million, then there would

  need to be 200 ophthalmologists to fulfil the World Health

  Organization suggestion.
- It is difficult to arrive at an accurate estimate of the number of doctors practising ophthalmology.
  - a) There are 110 medical practitioners in Ontario who are certified by the Royal College of Surgeons of Canada as specialists in ophthalmology.
  - b) There are about 12 men practising ophthalmology in Ontario who have not been certified by the Royal College.
  - c) There are about 55 doctors qualified both in ophthalmology and otolaryngology and as some of these do work in both specialties while others concentrate on one or the other, it is impossible to arrive at an accurate figure. Perhaps we might suggest 27 or 28. The total then would be in the

vicinity of 150, certainly less than the number calculated from the World Health Organization suggestion.

- 7. The shortage is relative and varies from area to area. About 1/3 of the total is located in metropolitan Toronto, another 1/3 divided between Ottawa, Kingston, London, Hamilton and Windsor, the remaining 1/3 for the rest of the province. About 75 ophthalmologists practice in the university cities Ottawa, Kingston, Toronto and London.
- 8. The rather centralized location of ophthalmologists (along with most other specialists) does not mean that the patient in small centres and in rural areas need suffer for lack of medical eye care.

  He can consult his family physician, never far removed, who can always arrange for immediate specialist attention for any condition which in his opinion requires such care.

# Reasons for Shortage of Qualified Ophthalmologists

- 9. Training courses recognized and approved by the Royal

  College of Surgeons of Canada are obtainable only in Toronto,

  London and Kingston-Ottawa (combined.) The total output

  of fully trained specialists is only about 7 or 8 per year.

  As mentioned above, this number is reduced because about

  50% of the graduates return to the provinces from whence
  they came.
  - A great deal of organization is mandatory along with adequate teaching personnel, suitable hospital accommodation and physical equipment and these are available only in the larger centres. At the moment only university cities afford these necessities.

- There must be readily available clinical material associated with the physical facilities and usually this also is found only in the larger cities.
- 4) Most hospitals, not affiliated with a university, place their eye service (if any) under the department of surgery and no special space, equipment or facilities are provided. Thus, there is no possibility of carrying out any special training in ophthalmology in most hospitals in Ontario.

# Recommendations for Increasing the Supply of Qualified Ophthalmologists

- 10. 1) Present provincial training facilities being now utilized to the full, it is obvious that they must be expanded. There is little difficulty in expanding the existing facilities for lectures and classes in the basic sciences. It is in the fields of clinical instruction and internship that the present university facilities would be overtaxed by the addition of more trainees.
- If proper equipment and facilities were made available, adequate clinical training could be provided in non-university hospitals (as well as university ones) and the present supply of fully trained personnel would be enlarged significantly. This is attested by the fact that there were 72 applicants for the five available places at one of the training centres.
- 12. 2) In order to implement the above, it would be necessary for hospital boards and the Ontario Hospital Services Commission to recognize ophthalmology as a separate, autonomous department and set aside space, personnel and funds to develop and maintain such services.

- 13. 3) These services must be under the control of ophthalmologists and completely divorced from the departments of surgery and otolaryngology.
- 14. 4) Adequate equipment for modern methods of diagnosis and treatment are lacking in almost all hospitals except those associated with universities. It should be pointed out that these physical requirements are relatively cheap when compared with the expensive machinery required in some branches of medicine. It is our opinion that the purchase of our equipment and instruments would benefit a much larger segment of the population than would the much more expensive equipment mentioned above.
- 15. 5) To obtain the full benefit from the postgraduate ophthalmological training now available, new courses should be set up in the other provinces and old ones expanded.
- 16. 6) In addition to the increased physical plant described above,it will be necessary to provide more para-medical personnel.
- a) Ophthalmic Nurses: Courses could be established in the university hospitals to give special training to graduate nurses in the clinical and operative care of the eye patient. Candidates could be sent by other hospitals to obtain this training. On completion, they would return to assist in the establishment and direction of proper ophthalmic departments in their own hospitals. Their very presence would do much to attract and keep ophthalmologists in the area.
- 18. b) <u>Technicians</u>: Some of the investigation and treatment procedures necessary in a well run eye department can be carried out by

technicians under the direction of an ophthalmologist. At the present time there is very little opportunity for acquiring such technical training in Canada and thus interested people must leave the country to take the desired appropriate course. They may not return. This instruction could be given at the university centre.

# Recommendations for Improving the Geographical Distribution of Ophthalmologists

- 19. Hospital facilities must be broadened or adjusted in such a way that a separate ophthalmological service can be established.
  - Proper and adequate equipment must be purchased so that the eye patient may be examined accurately and completely.
  - 3) An operating room must be set up and furnished with complete physical requirements.
  - 4) Adequately trained para-medical staff must be obtained to provide total ancillary care for the eye patient.

# SURVEY OF FIRST-YEAR MEDICAL STUDENTS

# 1. Analysis

As a preliminary step towards determining methods of providing medical services to residents of rural and small urban communities in the province, the Ontario Medical Association surveyed classes of first-year medical students in Ontario Universities in the 1950-51 term.

- Table 1 shows that of the 318 students enrolled, 47% came from the five largest cities, and 35% from the remainder of the province.
- 3. Only 27% are now practising in the large cities, and only 25% in other areas of the province.
- 4. It is significant that these two groups combined total only
  52% of the 1950-51 enrolment. Of the remaining 48%,
  more than half are practising outside the province (chiefly
  overseas, in the United States and in British Columbia), and
  23% are not licensed to practise in Ontario. (This group
  includes drop-outs from the university course, and students
  registered in other provinces).
- 5. The ratio of medical students per 10,000 population is shown in the following table:

Home town on enrolment	<u>1950-51 term</u>	1961-62 term
Toronto	. 80	. 76
Ottawa	1, 12	. 69

Home town on enrolment	1950-51 term	<u>1961-62 term</u>
Windsor	1.62	, 61
London	1, 15	, 93
Hamilton	. 50	. 45
Total five cities	. 88	. 72
Total other Ontario	. 43	, 43

- 6. These statistics indicate the metropolitan centres contribute about twice as many medical students as does the rest of the province. The figures varied from .88 per 10M population in 1951 to .72 in 1961 for the large cities, and was static at .43 per 10M population for the rest of the province.
- 7. London, a medical school centre, is the heaviest contributor of medical students. Although only half the size of either Windsor or Hamilton, which do not have medical schools, London contributes almost as many students as the two larger cities combined.
- 8. The survey of 1950-51 students indicates there is no ground for the suspicion that under-doctored areas suffer because medical graduates from Ontario universities are swarming into the big cities. The large cities contribute more students to medical schools than they get back in the form of graduates. The same is true, but to a lesser degree, of the smaller centres.
- 9. Other provinces and other countries, which contribute 18% of students, attract 25% of graduates, according to the tabulation. However, it is likely that another 8% go to the United States to

register after graduating in Ontario. This group is included in the 23% who are not licensed to practise in Ontario. This group is included in the 23% who are not licensed to practise in Ontario, and is arrived at after deducting the normal wastage rate of 15% through drop-out.

- 10. If these figures are an accurate criterion, it can be assumed that by the mid-1970s, only 52% of the students who enter first-year medicine in Ontario universities this year will be practising in Ontario.
- Table 2, which shows the origin of first-year students in Ontario medical schools during the five-year period from 1957-61, indicates there has been no significant change since 1950-51.
- 12. In 1950-51 the five largest cities contributed 47% of the students; other Ontario centres contributed 35%, and 18% came from outside the province. The five-year averages for 1957-61 showed 48% came from the big cities, 34% from other Ontario centres, and 18% from outside the province.

# 13. Survey of First-Year Medical Students in Ontario, 1950-51 Term TABLE 1

	Home	Address
	On	
	Enrolment	Today
Toronto	87	50
	27%	16%
Ottawa	22	13
	7%	4%
Windsor	20	8
	7%	2%

	Home	Address
	On	m - 1
	Enrolment	Today
London	11	5
	3%	1%
Hamilton	10	11
	3%	3%
Total Metro Areas	150	87
10011110110	47%	27%
Other Ontario	112	80
	35%	25%
Out of province	59	<b>7</b> 8
	18%	25%
Not licensed in Ontario		73
		23%
Totals	318	318

14. Addresses of Students on Enrollment in First-Year Medical School 1957-1961

# TABLE 2

	U. of T.	Ottawa Western 1957-58			Queen's	U. of T.	Ottawa Western 1958-59			Queen's	
Toronto	88	3	(111)	5	15		107	8	(124)	1	8
Ottawa	1	13	(20)	0	6		0	12	(18)	0	6
Windsor	1	1	(3)	0	1		1	3	(12)	5	3
London	1	0	(20)	19	0	I	0	0	(17)	17	0
Hamilton	6	2	(21)	5	8		4	1	(11)	4	2
Total Me Areas		19	(175)	29	30		112	24	(182)	27	19

1	U. of T.	Ottav	wa W 1957-		Queen's	1	U. of T.	Ottaw	a We		n Qu	een's
Other Ontario	60	9		21	36		41	13		31		31
Out of Province	15	44		3	9		15	31		4		16
TOTALS	172	72		53	75	I	168	68		62		66
			(372)						(364)			
			1959	-60		Ï			1960-	61		
Toronto	107	1	(119)	5	6		107	2	(118)	5		4
Ottawa	0 '	16	(25)	0	9		1	12	(18)	0		5
Windsor	4	2	(8)	2	0	Ī	0	3	(7)	3		1
London	1	0	(21)	20	0		1	1	(15)	13		0
Hamilton	8	0	(16)	1	7		5	0	(12)	4		3
Total Me Areas		19	(189)	28	22		114	18	(170)	25		13
Other Ontario	39	10	(119)	29	41		53	14	(148)	29		52
Out of Province	11	33	(55)	1	10		10	38	(66)	6		12
TOTALS	170	62	(363)	58	73		177	70	(384)	60		77
	1961-62							Five	Year T	Totals		
Toronto	109	3	(124)		9		518	17	(596)			42
Ottawa	2	14	(26)	0	10		4	67	(107)	0	6%	36

	U, of T.		Western 961-62	Queen's	U, of T.		va Western ear Totals	Queen's
Windsor	0	0 (3	3	0	6		13 (33) 29	
London	1	0 (1'		0	4		85 (90) 5%	
Hamiltor	n 8	0 (14	_	1	31		19 (74) 4%	
Total Me Areas		17 (18	<b>2</b> 7 34)	20	563		136 (900) 48%	
Other Ontario	34	8 (12		51	227		141 (633) 34%	
Out of Province	17	45 (72		8	68		16 (330) 18%	
TOTALS	171		60 30)	79	858 46%	18%	293 16% 1863)	

# ONTARIO MEDICAL ASSOCIATION COMMITTEE ON MATERNAL WELFARE

- The Maternal Welfare Committee of the Ontario Medical
   Association was established in 1957 for the purpose of studying ways and means of improving maternal care in this province.
- in each district consisting of interested obstetricians, general practitioners, internists, anaesthetists, pathologists, and other medical men. Representatives of each of these study groups who are certified obstetricians and gynaecologists personally investigate every maternal death that occurs in Ontario, after which the facts are discussed by the local study group and an attempt is made to determine preventability and how the care might have been improved. The results of these investigations are forwarded to the central committee in Toronto for further discussion and study. Twice each year all the committees meet in Toronto to discuss their mutual problems.
- 3. One member of the study group in each district of Ontario is appointed as a consultant to the Ontario Department of Health in order to facilitate obtaining the necessary information.

  The committee is a fact-finding rather than a fault-finding committee, and each case is discussed anonymously without mention of the name of the doctor, patient or even the area.

  Secretarial and financial assistance has been made available through the Ontario Medical Association and the Ontario Department of Health.

- 4. Partly as a result of these studies there has been a gratifying reduction in the number of maternal deaths in Ontario from 108 in 1959 to 84 in 1960. In Toronto, where the study has been proceeding for ten years, the number of preventable deaths has dropped from 28 in 1952 to 12 in 1959.
- 5. The principal cause of preventable deaths in Toronto is criminal abortion. Toxemia, haemorrhage, infection and anaesthesia have been greatly reduced. However, 82% of the deaths in Ontario are still considered preventable or possibly preventable, so there remains a great deal of room for improvement.
- The committee has taken steps to publish articles in the medical and public press for the purpose of educating the public and the medical profession, in addition to presenting papers at various county society meetings, and has utilized other methods of publicising the need for better maternal care. We are particularly pleased with the tremendous enthusiasm shown by the medical profession in this work and the wholehearted co-operation extended on a purely voluntary basis.
- 7. We trust that the Royal Commission on Health Services will consider the importance of maternal welfare studies in making known their findings and recommendations.

APPENDIX #9

HAEMOLYTIC DISEASE OF THE NEWBORN

(Booklet attached)

# PROGRAM ON HANDICAPPED CHILDREN (foreward)

- This is one of the activities of the Child Welfare Committee of the Ontario Medical Association. It was established under a Sub-Committee of Dr. Fred Jeffrey, paediatrician of Ottawa, chairman of the Committee, and Dr. John Rathbun, professor of paediatrics at the University of Western Ontario, with the financial support of the Atkinson Charitable Foundation.

  Dr. L. W. C. Sturgeon of Welland was appointed director of the study. An advisory committee was selected representing the various specialties who might be concerned with handicapping conditions and representatives of the para-medical group, education and social welfare.
- The program was initiated by a conference of representatives from official and voluntary agencies, held in November, 1960.

  At that time the Minister of Health, the Honourable Matthew B.

  Dymond, M.D., was the keynote speaker. The definition of a handicapped child was given by the chairman, Dr. Jeffrey, and the physical, mental, educational and social needs of the handicapped were outlined by five speakers representative of the three broad fields of health, education and welfare. Those attending gave unanimous support to the program. A report of this conference was published and this has been widely circulated throughout the province.
- Following this the director contacted representatives of the
   official and voluntary agencies and collected material on how the
   needs of the handicapped were being met across the province.

- This was done through personal interviews with professional and lay persons involved with programs for the handicapped.
- 4. As was promised at the first conference, a second was held one year later at Niagara Falls. Official and voluntary agencies and professional groups were again invited. To those delegated, a report of the findings of the director was given in advance of this meeting.
- This conference was limited to one hundred delegates and this 5. number attended for two and one-half days. The program was built around three workshops: one each on health, education and welfare. Ten individual workshops of ten delegates each with leaders from the advisory committee were convened. Preceding each workshop a keynote address was given by an outstanding speaker on the health, education and welfare needs of the handicapped. Dr. J. K. Martin, professor of paediatrics, at the University of Alberta; Dr. Samuel Laycock, faculty of education of the University of British Columbia, and Mrs. K. Johnston, director of social services, Children's Hospital, Montreal, respectively, dealt with those of health, education and welfare at general sessions. Again Dr. Dymond spoke at the final dinner on the rehabilitation needs of the handicapped. He was introduced by Dr. R. H. McCreary, president of the Ontario Medical Association. Dr. Rathbun, chairman of the Child Welfare Committee, presided at all general meetings. Cochairman, Dr. Jeffrey, outlined the hopes and aspirations of the Committee for the conference and in addition, instructed those present on workshop mechanics. The director gave his impression of handicapped children's programs across the province.

# SECTION ONE: GENERAL RECOMMENDATIONS FOR HANDICAPPED CHILDREN'S PROGRAMS IN THE PROVINCE OF ONTARIO

- 6. The sub-committee of the Child Welfare Committee of the
  Ontario Medical Association, on the advice of the Advisory
  Committee, through its own knowledge and experience, has
  carefully studied the recommendations made at the Second Ontario
  Conference and proposes:
- 7. 1) "That a co-ordinating council be established under the auspices of the Ontario Medical Association with representation from the three broad areas of responsibility health, education and welfare for the purpose of co-ordinating agencies and programs and integrating services."
- 8. It is significant that the same proposal, using slightly different wording, was made in the recommendations applying to the three fields of health, education and welfare. (Reference should be made to these recommendations in the appendix of this report.)
- 9. The delegates were of the opinion that this should be 'initiated' by the Association but it should not be held responsible for sustaining such a body, particularly financially. The advisory committee made many suggestions as to how such a council could be initiated and maintained.
- 10. 2) "That the Ontario Medical Association be asked to make a study of the ways in which adequate identification and registration of handicapped children may be effected."
  This proposal likewise originated from the three separate workshop

This proposal likewise originated from the three separate workshop recommendations.

- 11. The following conference proposals were given equal priority by the advisory committee:
  - 3) "It is emphasized that:
    - a) Doctors, hospitals, official and voluntary agencies should be interested in prevention, diagnostic and treatment services, research and education.
    - b) Para-medical treatment facilities, including dental care, on an ambulatory basis should be extended.
    - c) Inter-personnel communication and integration of effort is a basic necessity."
- 12. 4) "There is a need for the establishment of more hospital and community rehabilitation centres and workshop facilities.

  Standards for services as they apply to physical, mental, dental, physiotherapy, occupation therapy, speech therapy, educational and social services need to be established."
- 13. 5) "Research is needed in the fields of social welfare, the integration of services and the use of existing services in contrast to the need for new facilities. There is a need to increase the numbers of persons interested in, and capable of, research. There is a place for a body which would act as a clearing house for information on research, know the sources of interest, be aware of gaps and be capable of assessment of individual projects, thus eliminating duplication."
- 14. 6) "A provincial director is needed to indicate to individuals
  outside the metropolitan areas where special services
  might be obtained."

- Workshop leaders were members of the advisory committee who were able to attend and included: Doctors W. A. Wilford, J. S. Prichard, Bruce H. Young, and W. A. Hawke, Mr. D. A. MacTavish and Miss Helen Fasken. They were assisted by Dr. Jean Webb, chief of the Child and Maternal Health Division, Department of National Health and Welfare; Miss Bessie Touzel, executive director of the Ontario Welfare Council, and Dr. Wesley Dunn, registrar-secretary of the Royal College of Dental Surgeons of Ontario.
- At this conference, some 92 recommendations were made.

  These were subsequently categorized and presented to the advisory committee which was asked to assign priority for their implementation. In section No. 1 of this report, they are listed in order of priority. Other sections will deal with different phases of a recommended program based on the proposals outlined by the delegates and information of a relevant nature as to the problem, the programs that have been developed, and the services available or those in the planning stage.
- 17. The sub-committee of the Child Welfare Committee wishes to express appreciation to the members of the advisory committee and all others who have made these conferences and the entire program so successful.

## SECTION TWO: PROGRAM ORGANIZATION AND PLANNING

18. The advisory committee has studied the recommendations of the Niagara Falls Conference and the survey findings of the director.

In Section No. 1 highest priority has been given to the general recommendations arrived at during the conference.

- 19. In this section members of the committee have given priority to those recommendations having their particular interest.
  These priorities in certain instances are related entirely to their own professional pursuits. It is significant, however, that there is a crossing of professional lines to consider all the needs of the handicapped.
- 20. Based on this, and through the survey findings, the following essentials for effective programs for the handicapped are set down in order of priority of present unmet needs in this province:

#### 1) PERSONNEL

- a) Procurement
- b) Training
- c) Deployment
- d) Remuneration
- e) Auxiliary personnel
- f) Qualifications upgrading

## 2) SOCIAL CASEWORK PROGRAMS

- a) Personnel
- b) Research
- c) Casework techniques
- d) Welfare unit organization
- e) Liaison and integration with health and educational programs
- f) Institutions for emotionally disturbed and seriously disabled

# 3) BASIC PUBLIC HEALTH SERVICES - INCLUDING ESTABLISHED MATERNAL AND CHILD HEALTH PROGRAM

- a) Personnel
- b) Registers
- c) Prevention
- d) Statistics
- e) Expansion to include the whole province
- f) Integration with educational and social service programs

# 4) ADEQUATE HOSPITAL AND OUT-PATIENT SERVICES FOR DIAGNOSIS AND TREATMENT OF THE HANDICAPPED

- a) Convalescent
- b) Out-patient
- c) Travelling diagnostic teams
- d) Medical advisory committees for voluntary agencies

- e) Subsidization by the Ontario Hospital Services Commission
- f) Active treatment hospitals for assessment, treatment, and activation

# 5) SPECIAL EDUCATIONAL SERVICES

- a) Recreation
- b) Transportation
- c) Curriculum revision
- d) Larger units of administration for special services
- e) Mandatory educational facilities for the handicapped
- f) Special schools or classes to include facilities for the emotionally disturbed and dyslectic
- g) Co-operation with health and social service agencies, official and voluntary

# SECTION THREE: PROGRAM DEVELOPMENT GENERAL

- When the recommendations are put into effect in order of priority, existing programs will be expanded, enriched, altered, or made more effective for the handicapped. New ones will be developed as the need is shown, some existing ones may be discontinued or combined with others so that the needs of the handicapped will best be met.
- 22. These changes will happen sooner if co-ordinating councils are developed on a regional basis. This will best be done by stages. The logical approach would be first in university centres having medical facilities.
- 23. This applies in Toronto, London, Kingston and Ottawa. This would give coverage necessitated by geography and in respect to other local, regional needs. These would provide the base facilities.
- 24. Thereafter, it is suggested that district development would be a reasonable sequela. These could be located at Hamilton, Kitchener, Windsor, Peterborough, Sudbury and the Lakehead. These are natural geographic districts. University facilities

are established or are planned with educational and research facilities present or possible. Organized programs for physical assessment, treatment, education and vocational training and welfare and social services exist. Sault Ste. Marie is another possibility, although university facilities are not established at present.

- 25. It is advantageous for personnel training that university locations be chosen. Research is more likely to occur. Primarily, the disciplines of health, education and welfare will be present and instruction possible at the university level.
- The function and productivity of central and regional coordinating councils should be greater and more effective under
  this administrative set-up because regional offices of some of the
  official agencies are located in these centres. Specifically,
  welfare is one of the larger spenders of public funds.
- 27. Such a set-up does not preclude but rather will lead to the establishment of community councils for co-ordinating and developing local programs for the handicapped. A county or multi-county set-up is suggested, depending on the case load and the population.
- Registers: The second highest priority given to the various recommendations was in regard to the establishment of registers of handicapped. These must be developed at the community level. A few are already in existence such as those maintained by some organized health departments which are used primarily to provide records of individual cases. Statistically, these could furnish valuable information for the provincial

Department of Health. Good records are kept by the educational authority of all communities for those children who are attending school. Welfaregroups - Children's Aid Society, Family Service Bureaus or other welfare agencies - have indices of those who seek their help or come under their jurisdiction.

29. It was significant that in those areas with full-time health services, there was very little indication that the handicapped were unknown or hidden. In contrast to this, in areas adjacent to some of these centres, surveys had indicated many handicapped were found during house-to-house investigation.

Also, it is significant that information about these was supplied in many instances by the clergy.

# 30. Specific Considerations:

- 1) Personnel: A sufficient number of trained personnel is a prime requisite for any program for normal children, and the handicapped in particular. Further, these must be deployed in such a way as to give complete coverage based on need, even where geographical complications exist.
- 31. In addition, there must be facilities for primary training, upgrading of qualifications and the provision of refresher courses. The practical aspects of training should be in a situation where all disciplines are participating. This will facilitate inter-personnel and inter-disciplinary understanding.
- 32. Provision must be made to train personnel to undertake specific duties such as administration, specialized activity, technical tasks, or auxiliary and aid functions. Departments and agencies

must be organized to employ their personnel to the best advantage based on qualifications and existing needs.

- A major lack of personnel exists in the social service and welfare professions. Until these needs are met, all welfare, health and educational programs will be hampered and less effective. Society will be forced to spend money and resources without a full and proper return to the handicapped.
- An example of an effective program designed to overcome the lack of fully qualified personnel is that now provided by the Canadian Association of Occupational Therapists at Kingston.

  Graduates of this school were encountered throughout widely separated areas of the province. Their services were well accepted. This is given as an example of a new program designed to produce auxiliary personnel to a profession whose services are in great demand but in short supply.
- 25. During the survey, one was impressed with the number of educators who now hold responsible positions in their profession.

  By their own statements they began their careers as second-class professional teachers in small schools. Their continued professional progress could be attributed to primary motivation enhanced by the opportunity of upgrading their qualifications. This was possible through university extension courses and summer sessions. Other professionals, such as nurses and social workers, should have the same opportunity.
- 36. As a further illustration, the health services have for years

  used para-medical personnel -- nurses, nurses aides, technicians,

  clerks, administrators and volunteers. These relieve highly

trained personnel of routine tasks, thus allowing these scarce professionals to devote their full efforts and training to existing needs.

- 37. Finally, as has been recommended, educational authorities, through their guidance departments, must furnish information to students relative to opportunities that exist in the service professions.
- Professional societies, in turn, should make this information readily available for the guidance teachers. In addition, these same societies are in the best position to make known to universities and other sources of higher education, the need of instituting or expanding courses of instruction. Financial assistance to the universities or technical schools and the provision of training bursaries to students are the responsibility of society in general.
- 39. During the survey, the question was asked in all places where interviews were held, as to the adequacy of the numbers of doctors for health services supplying the needs of all children.

  The province can be divided into north and south. It was stated that the numbers of these were sufficient to take care of the needs of children in the southern portions of the province. In the north the matter of supply was complicated by a small population spread over a large area. In some of these areas no medical attention was available but it is doubtful if the economic conditions would warrant a physician establishing himself in private practice without some additional subsidy.

- 40. The para-medical group of personnel was repeatedly stated to be in short supply. This applies to nurses (whether hospital or public health,) occupational therapists, physiotherapists, and speech therapists. Contributing to this shortage, undoubtedly, is inadequate pay as compared to other professions. It should be appreciated that there is a high motivation among those interested in these vocations and this is being lost because of existing salary scales.
- The same question was asked about the number of available dentists and the answer was favourable in the places visited.

  However, it was pointed out that the profession is rapidly aging and that training facilities were inadequate to meet the future demand. The numbers of dental hygienists also are too few to properly supply this auxiliary type of service, a service which could be used to better advantage in co-operation with practising dentists and dental public health programs.
- 42. Psychiatrists are in short supply and this constitutes a serious bottleneck in the development of mental health programs.
- 43. In the educational field, it was stated that elementary school teachers with the proper background of training, were sufficient in number to supply the needs in most areas. At the secondary school level there was still a shortage but it was felt that this soon would be overcome.
- 44. Not enough fully qualified instructors in the special service field of education were available. The numbers attending summer courses to upgrade their qualifications to teach these special classes were increasing and this provided satisfaction to those concerned.

- 45. 3) Basic Public Health Programs including established Maternal and Child Health Services: As stated earlier, 80% of the province now has a basic public health program including maternal and child health services. This should be expanded to cover the whole of the province, and information would suggest that in the northern part it has received consideration and will be instituted.
- 46. Where basic public health programs exist, several considerations will be in evidence:
  - Through the keeping of registers the incidence of disabling conditions will be known;
  - b) Preventive measures are more likely to be adopted and operative for congenital conditions such as cerebral palsy, clubfoot, congenital heart disease; traumatic conditions such as accidents and those related to infectious diseases such as poliomyelitis, tuberculosis, and rheumatic heart disease:
  - c) The degree of severity of the condition can be assessed;
  - d) Rehabilitation will be possible in all situations. The completeness of this may vary depending upon facilities available and the severity of the handicap;
  - The educational, social service and psychiatric handicapping complications will receive attention.
- 47. The main consideration found during the survey was that there was less opportunity for these children to be missed or for a diagnosis and treatment not to be established early. In other words, there was a continuous sampling of the population to discover handicapped children.

- 48. It is emphasized that for statistical purposes it is imperative to use the International Statistical Classification of Diseases,

  Injuries and Causes of Death. However, as previously pointed out, this necessitated only minor changes in the keeping of registers.
- 49. Through parent interviews, it was appreciated that many persons are involved in the matter of case-finding. The public health nurse received high priority in this regard. Others were the clergy, neighbours and relatives.
- It has been emphasized in the recommendations from the conference that there was a lapse in child supervision after the age of one year. It was recommended in the pre-school age period, supervision should be continuous. There can be no question of the need for this. Child health conferences or clinics, nursery schools and other facilities for this age group would provide better opportunity to detect abnormalities. It must be emphasized that because of basic health services, parents and other interested persons will be alerted to the necessity of early diagnosis and treatment. It is considered that this is much more effective than to have poorly organized and irregular surveys promoted by service clubs or other interested groups.
- 51. The fundamental necessity of close supervision of all children

  by the practising physician or paediatric specialist, supplemented

  by clinics, is a prime necessity for early diagnosis and treatment

  after the cases have been found.

- Health services were first established for school-age groups and have been valuable. However, it should be particularly emphasized that a child reaching school age has much less opportunity for successful treatment than those found previously. While tests for the special senses, such as hearing and vision, are normally a part of school health services, consideration must be given to doing these sooner. In the school, proper equipment is essential, such as the routine use of an audiometer for hearing testing. In most areas the Snellen Chart is used for vision testing but this in itself is not enough. The conditions under which it is used and the qualifications of those making the tests are most important if these handicapping conditions are to be found and treated.
- of the province are dental health programs in operation and these again do not start until school age except in a few localities. To be the most effective they should be concerned with the pre-natal, infant, pre-school and school age groups.

  Where flouridation of communal water supplies is present, then the combination of this and dental health programs shows much greater value. Therefore, the universal flouridation of all drinking waters is a prime recommendation.
- Mental health facilities must be available to all age groups.

  It was emphasized by those working in this field that casefinding in the younger age groups made successful treatment
  much more possible and likely. In the school-age period, the
  availability of mental health diagnostic and treatment facilities
  was found to be too infrequent. In contrast, where these

were in existence and a high percentage of children requiring service was being seen in the clinics, educational and social services workers expressed their appreciation and satisfaction. The clinical approach to the problem, whereby the psychiatrist, psychologist, public health nurse, teacher and social worker discussed the individual problem found in the child and his family, created a sense of satisfaction among the workers. Those interviewed stated that a large measure of success resulted from this combined effort.

- 4) The Need for Adequate Diagnostic, Treatment, Hospital and Out-Patient Services: These needs are recognized in the recommendations made at the conference and during the survey. It must also be appreciated that "the total needs of the handicapped are similar to those of normal children except on a quantitative basis and we fail to make use of existing facilities in the light of existing knowledge and experience." To analyze these needs and for purposes of simplicity, it is best to categorize them into physical, dental and mental health. However, it must be recognized that at all times the successful treatment of the child depends on the concept of treating the whole child, not the integral parts.
- A medical advisory committee is a primary requisite in assessing existing services and developing new ones by voluntary agencies supplying assessment and treatment services. This committee should be advisory and not executive. The agency should define with the committee its duties and responsibilities.

  The role of the committee should be an active and not a passive one. The chairman of the advisory committee should be a

member of the board of the agency. The committee should provide a liaison with advisory bodies at other levels of jurisdiction within the agency. The committee should advise the agencies on standards of care which it provides, and finally, the committee should assume responsibility to point out gaps in knowledge and service and suggest ways in which these might be filled.

- a) Physical: Before any condition can be successfully treated, a diagnosis must be made. The role of the family physician is thus of paramount importance and he must have basic training and experience in handicapping conditions. It is essential, in addition, that he possess good knowledge of deviations indicating abnormalities so that the early recognition of these follows.

  However, if the child is not presented for diagnosis and treatment, little is accomplished. Thus parent interest and cooperation is essential. Thereafter treatment facilities, the availability of specialists and the means to provide treatment on a quantitive basis are essential whether in active treatment or convalescent hospital situations, followed by the use of outpatient resources.
- In this province, out-patient facilities, in addition to active treatment and convalescent hospitals, are found in the university centres having medical facilities and in the city of Hamilton.

  Spread across the province are 22 crippled children's treatment centres. These supply services of different quantitative adequacy and qualitative effectiveness. These are so classified, keeping in mind the desired needs of plant, assessment teams, personnel, equipment and accessibility.

- 59. Undoubtedly all of these crippled children's treatment centres

  are of value to the parents of the handicapped and therefore

  should receive community support based on need. However, unless

  the assessment and complete treatment programs necessary for

  most of the care of the handicapped can be provided effectively,

  it is questionable whether all these deserve the support of the

  Ontario Hospital Services Commission.
- 60. The prime reason for supplying of services in connection with

  existing facilities of the active treatment hospital is the

  conservation of personnel which is in short supply.
- could be recommended. This is the development of convalescent facilities or establishment of new ones close to the active treatment hospital. In this way scarce personnel could be used to the best advantage. The treatment atmosphere for long-term illness is present. The expense of supplying this is about one-half of that in the more costly active treatment centre.

  Education and welfare personnel can play their part. Outpatient resources can be well developed and the necessary beds will be more likely available.
- The assessment team ideally should be directed by the paediatrician. Other medical specialties and para-medical personnel should be resource persons. Education and welfare personnel to provide vocational training and rehabilitation services must be part of the team.
- 63. Such a concept can be developed at the community level in almost all areas of the province. Hospitals are now present

even in remote sections. Some types of active treatment must be on a regional basis because of the size of the case load and the availability of specialists. Rehabilitation centres are the recommended answer to the supplying of quantitative services. Where these are now operating, as for example, in Kingston, the program and results were impressive. A sufficient population to provide an adequate case load, however, is necessary.

- Central treatment services to complete the requirements of care and rehabilitation of the handicapped developed around medical schools of the universities are suggested. A new centre in Toronto built and operated by the Ontario Society for Crippled Children is an example of this. The stated purpose of this centre is for comparatively short periods of care. Thus, centres outside the city of Toronto, smaller and less elaborate, are needed to complement the base facilities.
- 65. It must be appreciated that some conditions, because they are fewer in number and require highly specialized treatment, will always have to be treated in one hospital. The Hospital for Sick Children in Toronto has developed an enviable reputation and for certain conditions it was noticed that children were being referred from all sections of Ontario.
- One of the reasons for this outlined development which is not mentioned often enough is the natural desire by most parents of the handicapped to seek out and exhaust all possibilities of curing or helping their afflicted child. Therefore, they will go from one professional person to another and try all types of treatment facilities. Much of this all-too-often

vain search for a cure could be prevented by those who are first consulted taking the time to listen to the parent's story and outline the different possibilities for cure or help. Some parents will still seek other sources of aid. Frequently, these are from irregular practitioners.

- b) <u>Dental</u>: The dental needs for the handicapped are the same as those of normal children except for the degree of severity and complications which require specialist service. This will involve close co-operation with other specialists outside the profession and those of the para-medical group, particularly speech therapists.
- Restorative treatment for caries is a major problem since the handicapped will, because of more exposure to carious producing agents and because of developmental factors, develop dental problems exceeding those of the normal.

  Another complicating factor is the difficulty of providing early dental care due to lack of ability on the part of the child to co-operate with the dentist.
- 69. Orthodontic problems are more frequent as a result of premature loss of foundation teeth and developmental anomalies.

  Peridontal disease more often will be a complicating factor because of a greater prevalence of predisposing causing. A major difficulty is the complications arising out of the need for dento-facial surgery, in the case of those children suffering from harelip and cleft palate.
- 70. To meet these needs requires dental specialist training and the provision of facilities to carry out much of this treatment

under prolonged general anaesthesia. Dental sections of hospital staffs are relatively common across the province. These should be expanded to provide close integration of effort between the dental and medical professions. In this way the interdependence of those treating the handicapped will be recognized.

- 71. Dental treatment must start very early in the life of the handicapped child and should be continuous to prevent additional disability. Preventive measures such as the universal fluoridation of communal drinking water supplies is a "must" for the handicapped because of the difficulties outlined above.
- 72. c) Mental Health: Mental health problems in themselves are one of the major causes of prolonged or short-term handicapping of children.
- The lack of facilities for short or long-term treatment of persons suffering mental illness either in the office or as hospital in-patients or out-patients, is one of the largest areas of unmet need. This is due to a lack of personnel and the physical resources necessary to solve the problem effectively.

  These deficiencies are recognized by those who are responsible at the provincial government level.
- 74. The solution would appear to be the development of facilities at the community level, either as part of the general hospital or in small institutions. Effective programs originating in both such situations were seen during the survey.

- 75. If the successful program for the control of tuberculosis is followed, these services could be developed by local boards responsible for the treatment, out-patient clinics and case finding. These facilities could be developed within the community on a county or regional basis. The central government would supply a major portion of the needed financial assistance as is being done at present. Additional out-patient services could be financed by voluntary agency and local government participation. The close integration of basic health, education and welfare services at the community level is imperative and as was seen in certain areas, a reality.
- 76. The custodial care of the totally disabled might well become the responsibility of the welfare authority with psychiatric consultation or assessment being provided by the specialist. It was noticeable across the province that parents whose children are likely to progress and improve are satisfied to send their children to a distant residential educational or treatment institution. However, when the child has been assessed as incurable or one who will make little progress, it was evident that parents desire to have these children close to them so that they might be visited often. The realistic appreciation, therefore, of the need for small custodial institutions at the community level can be understood. The children who come home for holidays during the year, although they may be attending institutions, provide the family contact, particularly when they are showing progress in their educational or vocational training.

- 77. The development of similar institutions such as Thistletown and Byron is recommended in association with each medical school. In addition, similar institutions, possibly smaller in size and in program, should be located in the northern part of the province. These hospitals are outstanding in concept and in operation.
- 78. 5) <u>Vocational and Employment Programs for the Handicapped</u>:
  Of the conference recommendations, the following were assigned priority:

"It is recognized that the handicapped should be given every opportunity to acquire vocational training suitable to their physical, mental and educational capabilities.

Co-ordination of vocational training with job placement services was emphasized and this could best be provided at the local level. To facilitate this, local employment opportunities should be continually surveyed."

- 79. The committee suggests that vocational training is essentially the responsibility of the educational authority. The resources of the National Employment Service will be invaluable either through the regular or special branches.
- Similarly in rehabilitation, there must be close integration
  between many disciplines; for example, "activation" should
  begin once a diagnosis is made and treatment started. This
  will be progressive as the physical or mental needs of the
  handicapped are met and could be termed medical
  rehabilitation. When the patient is discharged to the convalescent
  hospital from the active treatment bed, or while still under
  active treatment for long-term illness, education must be

continued or commenced. This is educational rehabilitation which now must be associated with medical rehabilitation.

When the patient is ready for discharge to an out-patient status, the welfare and social services will play their part so that the patient can become self-supporting. The Department of Welfare of the province has provided rehabilitation services for many years and these have been appreciated by many workers in the official and voluntary agencies and by the professional groups.

The Department of Health recently has accelerated rehabilitation services for patients discharged from mental hospitals and sanatoria.

- The extent of participation by different disciplines in vocational and employment group programs will vary in intensity depending on the patient's progress and particular needs. There can be no clear-cut definition of responsibility and there will be "grey" areas demanding close co-operation between those concerned.
- is being recognized and provided but the endeavour must be, if possible, to have the handicapped become self-supporting.

  Subsidies may be necessary for their support until this is possible. Home training, apprenticeship and special training school instruction are recommended. Close contact must be maintained between the health, education and welfare vocational officers, with the employment officers and the various medical, dental and para-medical professions.
- 83. 6) General Education, Special Services, and Nursery Schools:
  It is not to be assumed that education is considered to have the

lowest priority but rather it must be emphasized that the educational services in the province have kept pace with the needs and possibly have progressed faster than the other essential services for the handicapped.

84. Of the conference reports, the advisory committee recommended the following priorities:

"Special educational facilities should be mandatory, not permissive. It was emphasized that every child is entitled to the maximum education possible depending on his ability to absorb this. To provide this it was recognized that the curriculum for the normal child would not always be suitable for the handicapped, although if it were possible, the handicapped should be educated in the regular classroom rather than being segregated."

- Where special schools or classes are to be instituted, it was the opinion that this could be done only through larger units of administration, possibly best on the county level. The county school board, would have jurisdiction over the special services provided by all the school boards within the county or a suitable administrative area.
- 86. It was recognized as well that a large number of children are emotionally disturbed and some have dyslectic handicaps. The survey indicated that the emotionally disturbed might constitute 10% of the school population. Where multi-handicapped children are found in sufficient numbers, research is needed to determine what form this education should take.

- During the survey the schools at Belleville and Brantford were visited. These residential facilities for the deaf and blind were most impressive as to their physical set-up, the type of instruction and the progress of the students. There was no evidence that the children were suffering because they were segregated and they were very happy in their residential situation.
- 88. As well, special classes and schools for the handicapped were seen. It must be realized that special schools could not be provided for all the handicapped. The case load and the population would not justify this and, therefore, the provision of special classes has been made in the smaller cities.
- 89. In other areas handicapped children attended the regular classes and this created no problems where the boards of education made provision for transportation. It was felt that transportation should be the responsibility of the educational authority and that recreation programs should be developed because some children with handicaps demonstrated a remarkable aptitude to participate. This was mentioned specifically in regard to the retarded child who apparently has a great deal of natural ability in the water.
- 90. For the mentally retarded the training program in retarded children's schools is most impressive. The number of children in attendance, being over two thousand, represents more than the resident population of children at Smith's Falls Ontario Hospital.
- 91. It is significant that the cost of supplying instruction in a

special school where the child lives at home is approximately the same as that required to support and educate the handicapped child with similar physical defects in the residential situation. However, the cost to society for the training of a retarded child in a retarded children's school is considerably less than the cost of maintaining the same child in one of the Ontario Hospital training schools.

- To make any educational program effective for the handicapped child it was recognized that there must be a very close co-operative effort put forward with the other official and voluntary agencies. This has been recognized by the Department of Education which makes grants to two voluntary agencies; the Canadian Hearing Society and the Canadian National Institute for the Blind. These two organizations provide vocational training and employment and placement services to the graduates of the two schools operated for the deaf and the blind.
- Again it must be emphasized that the Department of
  Education through its special services branch has been
  alert to the needs of the handicapped in the province and
  has supplied the finances and the training opportunities for
  teachers to make the activities of local boards of education
  effective on behalf of these unfortunate children. The
  principle of consolidated schools is almost universally
  accepted. If the principle of larger units of administration
  for the special services comes about on a county or
  regional basis, it would seem that most of the needs of the

handicapped, as far as education is concerned, will be met effectively.

94. SECTION FOUR: THE AMOUNT OF HANDICAPPING AND THE FACILITIES FOR THE ASSESSMENT, TREATMENT, HABILITATION AND REHABILITATION OF THE PHYSICALLY AND MENTALLY HANDICAPPED

## A. The Amount of Handicapping

There is no central register of the handicapped in this province. This does not mean that most, if not all, of these are unknown. Registers are maintained singly or as part of a general one of all children by most organized full-time health departments within the province.

- 95. Voluntary agencies tend to report the numbers of handicapped children as a percentage of the whole population. The errors associated with this method must be recognized because of the existence of multiple handicaps.
- in the province, 1,630 showed one or more abnormalities for a total of 1,854 abnormal conditions. (i) This represented almost 10% of the births of those born with handicaps as having multiple ones. It is doubtful if reporting was complete. Some conditions may not be recognized during the short time spent by the infant in hospital. Other conditions would develop or be recognized later in life before age 21.

  This is the age group with which we are concerned in this survey.
- 97. If we apply the information from the British ColumbiaRegister (ii) 75% of these had one disability; 20% had two

disabilities only; 4% had three disabilities and 1% had four.

Of this total we would expect to find 1,230 children with one,

325 with two, 60 with three and 15 with four disabilities.

- 98. It is possible from the Canadian Sickness Survey 1960 (iii) and the Annual Report of the Health Branch, Department of Health Services and Hospital Insurance, British Columbia 1959 (iv), to estimate the numbers of persons in Ontario with physical handicaps. These are given in the Sickness Survey as representing 1.8% of the population under the age of 15 and 1.6% under the age of 24. The British Columbia Registry reports these as 1.4% of the total population in 1955 and 1.89% for 1959. For practical purposes, the figure of 2% is used in their further discussions. It would seem that this might be the best estimate for this province because it represents individuals with handicaps.
- 99. It is estimated that the population under the age of 21 years in Ontario is 2,425,000 persons. Using 2% therefore, we could expect 48,500 as having some degree of physical and/or mental handicap in this age group.
- 100. Again using the British Columbia figures (v) the following most frequent conditions will be encountered:

Mentally retarded	18.3%	8,876
Strabismus	8.8%	4,268
Congenital malformation of the heart	7.2%	3,492
Impaired hearing and deafness	5.5%	2,668
Club foot	5.0%	2,425
Cerebral palsy	5.0%	2,425
Poliomyelitis	3.8%	1.843

- These estimates can be considered as reasonably accurate.

  For example, there are in schools for the retarded in

  Ontario a few more than 2,000 children registered with an

  I.Q. of less than 50 between the ages of six and eighteen

  years. It can be assumed that one-half of this number or

  1,000 are in the preschool and post-school ages under 21

  years. This would represent approximately 6,000 children

  at home or resident in the various institutions.
- 102. The Annual Statistical Review for Ontario Hospitals (vi)
  for the year of 1959 reports 5,143 children under the age of
  24 as on the books of the Department of Health. Therefore,
  applying the information from British Columbia would appear
  to be a valid procedure in determining the number of
  handicapped among the population of this province under the
  age of 21 years.
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further proof to the earlier statement that the disabled probably do not represent more than 2% of the total population.

- In this province these are provided by:
  - a) General practitioners, specialists and travelling diagnostic teams;
  - b) Hospitals and institutions (private and public);
  - c) Treatment centres.
- reported as part of the physicians' notice of birth or stillbirth.

  In addition to these congenital conditions, the family physician or the specialist is the one who usually will detect any deviation from the normal occurring after birth. To do this, he must be consulted by the parents of all children on a regular and periodic basis of attention. When parent interviews were carried out during the survey, it was significant that the mother of the child was the first to notice a change from normal development; usually this was related to other children in the family. Others frequently mentioned were near relatives, neighbours, public health nurses and the clergy. Invariably, all of these were insistent that the child be brought under medical attention.
- Within the province there was little evidence of any lack of available medical attention except possibly in some of the remote areas of both the southern and northern parts.

When organized public health services existed, featuring maternal and child health programs, handicapping conditions were usually known and some attempt at treatment at least was forthcoming. If this was not provided by the parents using their own resources or through the activities of the official and voluntary agencies, it was because of resistance on the part of one or more parent. Travelling diagnostic teams sponsored by service clubs and/or voluntary health agencies still conduct clinics in both the southern and northern parts but at present these are more essential in the northern areas. These teams were appreciated both by the profession and those working in the official and voluntary agencies.

## 107. C. Hospital's and Institutions

Those close to the problems of handicapping estimate that one-half of the parents of these afflicted children will be able to provide the necessary diagnostic and treatment services themselves. These are obtained through the regular channels of family physician and the various specialists. For the remainder, out-patient facilities at hospitals in London, Hamilton, Toronto, Kingston and Ottawa provide these services. Not all of those who were in a position to assess these facilities agreed that in all locations these were ideal. Primarily the problem related to finances and it was obvious that the fee of \$1.50 per visit was totally inadequate.

108. There are 20 Ontario Hospitals operated by the mental health branch of the Department of Health. Ten of these

are regarded as regional psychiatric centres which offer a broad and comprehensive range of diagnostic and treatment services for the mentally ill. Of the remainder, four are concerned with the mentally retarded and the other six have a special function such as the treatment of the tuberculous, mentally ill, the epileptic and those who have committed a serious criminal act or offence.

- 109. Of the 25 out-patient services identified with hospitals for the mentally ill, 21 serve both adults and children. Of the other four, three serve children exclusively. Seven of the 25 clinics provide a regular travelling clinic service to 19 population centres in their immediate vicinity and four provide day care.
- 110. During 1960, 42% of the patient's were children age 17 or under.
- 111. A 1,200-bed Ontario Hospital School for Retarded Children
  was opened in June of 1961 at Cedar Springs. Two new
  300-bed hospitals are under construction at Goderich and
  Owen Sound. These will provide a broad comprehensive
  psychiatric service to both children and adults.
- the board of the Royal Ottawa Sanatorium, which uses vacant sanatoria beds, is a development which bids well to set a pattern for the successful treatment of in-patients and outpatients across the province. The principle so effective in the tuberculosis control program is one that could be well applied to the problems of the mentally ill. Fundamentally,

this means the development of local or regional treatment facilities, the provision of out-patient clinics and the co-ordination of the program as between the medical profession, the official and voluntary agencies and those supplying the care.

- 113. Altogether in the province there are now psychiatric units in connection with 17 general hospitals. These supply 532 beds altogether. This will be increased by the completion of construction of the 35-bed unit in Windsor and a 20-bed unit at Sault Ste. Marie.
- During the year 1960, 4,438 patients were admitted for a median length of stay of 22 days with fewer than 10% of the patients having to be transferred to a mental hospital or other institution.
- 115. It is interesting to note that two additional out-patient services were developed under local health departments in York County and Oshawa and one is planned for Halton County.

  Federal health grant assistance was used for initiating these.
- Two recent developments in the care of the mentally ill and retarded children are noteworthy and have received international recognition. The Research and Treatment Centre for Emotionally Disturbed Children at Thistletown provides accommodation for 65 children and is operating to capacity.

  It is estimated that there will be a yearly admission rate of 50 to 60. During 1960, 84 children were admitted to the hospital and 76 discharged. Sixty-four of these children returned to an active life in their home community.

- The Children's Psychiatric Research Institute at London
  will now provide 90 to 100 beds for assessment, research
  and short-term treatment for the retarded. Since establishment, this hospital has received 764 children for diagnosis,
  assessment and screening. When indicated, it is possible
  for the mother of the child to stay at the hospital with the
  patient. The day care program is now operating at this
  centre.
- 118. Sanatoria in-patient and out-patient care for tuberculosis is provided in the 12 sanatoria regionally located across the province. There was no evidence during the survey that the problem of the tuberculous was not being met to the satisfaction of all those concerned in any area. The program in the province for the control of tuberculosis is an outstanding one and the principles that made this effective are those that should be applied to any handicapping condition. Tuberculosis was the first cause of death in 1900 but by 1960 had been reduced to 2.6 per 100,000 population for a total of 157 deaths. This was the second consecutive year that Ontario showed the lowest death rate of any province in Canada. This disease affects all systems of the body and resulted in handicapping from mild to complete. The educational and social by-products are well known and need not be mentioned further, except to emphasize again the successful control that has been brought about by the employment of certain definite principles that can be used in other situations in all problems relating to handicapping conditions.

- All departments of government involved with treatment
  emphasize the difficulties of procuring and keeping staff.

  This was applicable not only to the medical but also the
  para-medical personnel required for the efficient operation
  of the service.
- 120. Dental treatment is provided by the general practitioner and specialist across the province. There has been a tendency to localize dento-facial surgery in the Hospital for Sick Children in Toronto and this situation undoubtedly will continue with regional expansion of facilities on a gradual basis. A recent report from the Research Institute of the Hospital for Sick Children, which was supported by the Atkinson Charitable Foundation, is most comprehensive and should become a reference for all those interested in the problem. The development of the specialty of orthodontia and the location of those so trained in smaller cities will do much to provide treatment for these handicapping complications.

### 121. D. Treatment Centres

In addition to, or complementing, the out-patient facilities listed, treatment centres have developed across the province. There are now 22 of these providing regional services.

Promoting these have been parent groups, voluntary and official agencies. Ones supplying a complete range of service, namely assessment, physio, occupational and speech therapy and educational instruction similar to that obtainable in a regular school, are located in Windsor, Chatham,

London, Kitchener, Guelph, Brantford, Hamilton, Toronto,

Oshawa, Kingston, Ottawa, Sudbury, Sault Ste. Marie and the Lakehead. The remainder of the total are located in some of these cities and others. These latter centres supply some services and are chiefly under the sponsorship of parent groups.

- they do not exist in local hospitals, or as a supplement to these facilities supplying care usually on a long-term basis.

  Ordinarily they are located in separate buildings removed from the active treatment or convalescent hospitals with one or two exceptions notably London and Brantford. In the latter city the treatment centre is located in the chronic wing of the general hospital and utilizes the services of the active treatment hospital for physic and occupational therapy.

  Those requiring speech therapy travel to Hamilton. This is a pattern that might well be adopted in other active treatment or convalescent hospitals located in smaller cities and larger towns of the province.
- types of treatment provided by medical or para-medical personnel. In assessing the treatment centres those having the general endorsement of the American Academy of Paediatrics might well be used. Ideally they would provide diagnosis, evaluation and planning for care with referral elsewhere for needed special tests or consultation not available at the centre.

- for example, in orthopaedic clinics, cast removals, minor brace adjustments, physical therapy treatment and parental instruction; in vision clinics, refraction and prescription or fitting for glasses; in hearing clinics, speech instruction with referral for radiation treatment and antibiotic therapy; in cardiac clinics, prophylactic therapy and preliminary assessment; in epilepsy clinics, regulation of drug therapy.
- 125. Recommendations for additional treatment or further study
  to be carried out in hospital, school, or by the physician,
  public health nurse, social worker, physical therapist or
  other specialist.
- 126. Guidance and counselling with parents and child and planning for follow-up care in the home.
- 127. In e stablishing these services, three factors are of basic concern given here in order of their importance:
  - Quality and number of professional persons and coordination of their skills;
  - 2) Availability of diagnostic and laboratory facilities;
  - 3) Physical plant.
- largely on how they are used in operating these clinical services. The following general observations might be made in regard to the clinic personnel. The basic team and its well-equipped special clinic for the handicapped children ideally might consist of:

Paediatrician;

One or more medical or dental specialists;

One or more nurses (at least one should be a public health nurse):

One or more therapists - example, speech, physical, occupational;

Appropriate technical personnel (for example, brace maker, audiometric technician);

Other appropriate professional persons (example, nutritionist, psychologist as consultants);

Clerical staff;

Teachers and volunteers;

Social workers.

- While clinics can function with smaller professional staff, these should be available for consultation or for referral. To provide the inter-disciplinary team approach it is necessary that they are available to sit down and discuss the child's particular problem and how this will be treated most effectively using the resources available.
- is doubtful if any of these treatment centres would qualify completely. The reasons for this are related to the availability of properly trained personnel and finances.

  The cost of operation of the various centres visited varied, depending on the extent of the treatment program. At London, the cost for 543 children seen during a one-year period who received approximately 11,500 treatments, was given as \$54,334.00 (or approximately \$100. per

child per year or \$5. per individual treatment.) Thus it will be appreciated that the fee allowed of \$1,50 for an out-patient visit in a general hospital is most inadequate if a child is to receive proper and effective treatment.

- 131. The extent of the services provided in the other centres throughout the province varied as did the cost of providing this service.
- 132. The most recent development has been the opening of a treatment centre in Toronto by the Ontario Society for Crippled Children. This centre, which cost over \$4,000,000. is designed to provide relatively short term in-patient care as well as longer term out-patient service. All of the treatment services will be available as well as the provision for some service for brace makers and those trained in prosthetics and appliance construction and maintenance. Hostel facilities will be available for parents of children who have to travel distances to obtain care and treatment. The stated purpose of this institution is to supplement the activities of other treatment services across the province by providing assessment, initial treatment, education and vocational assessment and the provision of applicances and prosthetics. It is classed as a hospital by the Ontario Hospital Services Commission and it is expected that the major part of the financial requirements will be derived from this source.

# 133. SUMMARY

In this province there are approximately 157,000
 live births per year. Of these in one year, 1,630 showed

one or more abnormalities for a total of 1,854. Of the estimated 2,425,000 population under the age of 21 years, it is estimated, using the various sources of information obtainable, that there are 48,500 children having one or more handicapping conditions. The first year of life is a particularly hazardous one for children born with congenital defects, as 73.7% of all the deaths attributed to congenital defects occurred in the first year of life.

- 134. 21 Facilities for diagnosis and treatment are available by general practitioners, specialists and travelling diagnostic teams in all areas of the province. Hospital facilities exist and are financed by the Ontario Hospital Services Commission so that there is no reason for any child to be taken beyond the borders of the province for adequate treatment unless the parents so desire. The need for early diagnosis to bring about successful treatment of handicapping conditions is recognized, thus it is imperative that although the numbers of handicapping conditions seen by the family physician will be small (only 2% of the population) these must be diagnosed and the parents informed of the various treatment resources available for their children. This will more likely happen when continuous and periodic assessment of the child's growth and development is provided by the general practitioner augmented where necessary by the various specialists.
- 135. 3) Out-patient facilities exist as part of the active treatment hospitals in London, Hamilton, Toronto, Kingston and Ottawa. Twenty-two treatment centres

complementing these facilities are located in these and other small and large cities of the province. The quality and quantity of service provided varies and the limitations imposed by a lack of personnel and finances and the cost of operation are outlined.

# 136. Reference s

- (i) Ontario Department of Health Division of Medical

  Statistics Special Report No. 9 P. P. 1
- (ii) Department of Health Services and Hospital

  Insurance British Columbia Division of Vital

  Statistics Special Report No. 53 P.P.29
- (iii) Canadian Sickness Survey 1950-1951 P. P. 113
- (iv) Department of Health Services & Hospital Insurance 
  British Columbia Division of Vital Statistics 
  Special Report No. 37 P.P. 20
- (v) Ibid Special Report No. 53 P.P. 15
- (vi) Ontario Department of Health Annual Statistical

  Review Ontario Hospitals 1959 P. P. 33

#### 137. HANDICAPPED CHILDREN - NEW CASES REPORTED HAMILTON CITY HEALTH DEPARTMENT - 1951-1960

	I.C.D.	School Age Pre-Scho				Schoo	l Age
DIAGNOSIS	Code	No. % Rate* No. %			. %	Rate*	
		1					
1. Infective and parasitic							
diseases	001-138	154	8.8	34	79	6.1	28
Tuberculosis, pulmonary	001-008	11	0.6	2	-	-	-
Other forms of tuberculosis	010-019	10	0.6	2	-	-	-
Poliomyelitis	080-081	111	6.3	24	70	5.4	25
Infectious mononucleosis	-093	14	0.8	3	-	_	_
2. Neoplasms	140-239	27	1.5	6	16	1.2	6
Malignant neoplasms	140-205			3	_		
Benign and unspecified							
neoplasms	210-239	11	0,6	2	11	0.8	4
······································	210 200		10.0	1 -		0.0	1
3. Allergic, endocrine							
system	240-289	66	3.8	14	22	1.7	8
Asthma	241	28	1.6	6		1	-
Diabetes mellitus	260			7			
Diabetes memus	200	1 94	1. 5	"			
4 Discourse of the Bland	000 000	1.77	1 1 0		_	0.4	2
4. Diseases of the Blood	290-299	17	1.0	4	_5	0.4	Z
E Burney 1							
5. Mental, psychoneurotic	000 000	0.5.4			0.03		
and personality disorders	300-326				201	15.5	72
Disorders of Character	320-324		1.6	6	24	1.8	8
Mental deficiency	325	222	12,6	48	177	13.7	64
				}			
6. Central nervous system	330-398			1		20.0	93
Cerebral palsy	351		2.0	8		9,0	42
Epilepsy	4	129	7.3	28	40	3.1	14
Diseases of the eye	370-389	1	4.4	17	40	3,1	14
Diseases of the ear, hearing	391-397						
	398	207	11.8	45	45	3.5	16
7. Diseases of the circulator	ry						
system	400-468		14.5	56	<u>32</u>	2.5	12
Rheumatic fever	400~402	170	9.7	37	-	-	
Chronic rheumatic heart				Ì			
disease	410-416	63	3.6	14	800	-	-
Arteriosclerotic and degener	-						
ative heart disease	420-434	14	0.8	3	-	-	-
Diseases of veins & other dis	eases						
of circulatory system	460-468	-	-	-	18	1.4	6
8. Diseases of the respirato	ry	ĺ					
system	470-527	11	0.6	2	-		_
9. Diseases of the digestive							
system	530-587	21	1,2	4	29	2.3	11
Diseases of the stomach and					_		
duodenum	540-545	-	_	_	19	1.5	7
Other diseases of digestive	210 010				10	1.0	
system	rest	13	0.7	3	10	0.8	4
						3.0	1

			,	ı	1		
10. Diseases of the	590-637	35	2.0	8	19	1.5	7
genito-urinary system							
Nephritis & nephrosis	590-594	32	1.8	7	17	1.3	6
11. Diseases of the skir	1						
& cellular tissue	690-716	2	0.1	-	4	0.3	1
		-					
12. Diseases of the bone	es						
& organs of movement	720-749	137	7.8	30	177	13.7	64
Arthritis	720-727						
	-738	-	-	-	10	0.8	4
Osteomyelitis	730	12	0.7	3	-	-	~
Osteochondritis	732	59	3.4	13	-	-	-
Muscular dystrophy	744.1	14	0.8	3	-	-	-
Curvature of spine	745	19	1.1	4	-	-	-
Feet	746-748-						
	749	25	1.4	5	145	11.2	52
13. Congenital Mal-							
formations	750-759	116	6.6	25	378	29.2	136
Spina bifida	751	-	-	-	33	2.6	12
Hydrocephalus	752	-	-	-	35	2.7	13
Cataract	753.0	18	1.0	4	20	1.5	7
Agenesis brain	753.1	14	0.8	3	11		
Heart	754	42	2.4	1	106		
Cleft palate & harelip	755	11	0.6	, 2	81	6.2	29
Digestive system, other							
congenital malformation	of						
bone and joint	758	10	0.6	2	23	1,8	8
Other congenital malform	nation				1		
of bone and joint	758.6	-	-	-	29	2.2	11
Other unspecified congenital							
malformation not elsewh	ere			i			
classified	759	-	-	-	22	1.7	8
14. Certain diseases of							
early infancy	760-776	-	-	-	13	1.0	5
15. Symptoms, senility							
ill-defined conditions	_780-795	11	0.6	2	4	0.3	1
16. Accidents, poisoning							10
violence	E800-999	153	8.7	34	29	2.2	10
Late effect of the accide		150		0.0	0.00		10
injury	E962	150	8.5		27	2.1	
Residual(unclassified)	?	42	2.4	9	27	2.1	10
FD 4 3		1 750	100.0	200	1 004	100.0	166
Total		1,759	100.0	383	1,294	100.0	400

<sup>\*</sup>Rates per 100,000 estimated population in these groups.

#### 138. HANDICAPPED CHILDREN - DUFFERIN COUNTY - 1960

Population under 20 years - 6,950

	I.C.D.				%
DIAGNOSIS	Code	N	0,	% P	pulation
1. Infective and parasitic disease					
D-111141	001.138		_5	3.8	
Poliomyelitis - residual paralysis	000 001	-			
par ary sis	080-081	. 5			
2. Neoplasms	140-239		_2	1.8	
Malignant neoplasms	140-205	_			
Benign neoplasms	210-239	1			
3. Allergic, endocrine system	240-289		4	3.0	
Diabetes	260	1		""	
Obesity	287	3			
A Discourse (Shi)	000 000				
4. Diseases of blood	290-299	0	_0		
5. Mental, psychoneurotic and				İ	
personality disorders	300-326		_22	16.0	
Disorder of character	320-324	.3			
Mental deficiency	325	19			
6 Control nonvious sustain	220 200		4.5	20.5	
6. <u>Central nervous system</u> Cerebral palsy	330-398		41	30.7	
Epilepsy	351 353	13			
Visu	370-389	_			
Diseases of the ear, hearing	391	12			
	001				
7. Diseases of the circulatory					
system	400-468		_3	2.0	
Other	460-468	3			
8. Diseases of the respiratory					
system	470-527		_0		
9. Diseases of the digestive					
system	530-587		_0		
10. Diseases of the genito-urina	rv				
system	540-637	1	_1	0.7	
11. Diseases of the skin and					
cellular tissue	690-716	0	_0		
12. Diseases of the bones and or	gans				
of movement	720-749		12	9.0	
Dermotomyositis	710	1			
Osteochondritis	732	2			
Curvature of spine	745	2			
Feet	746-749	7			

13. Congenital malformations	750-759		23	17.5	
Spina bifida	751	5			i
Hydrocephalus	752	1			
Heart	754	2			
Cleft palate and harelip	755	5			
Congenital malformation of bones					
and joint	758	7			
Other congenital malformations					
of bone and joint	758-6	3			
14. Certain diseases of early					
infancy	760-776	0	_0		
15. Symptoms, senility and ill-					
defined conditions	780-795		18	13.5	
Speech	326	18			
16. Accidents and violence	E800-990	3	_3	2.0	
Total			134	100,0	1.9

# 139. <u>SECTION FIVE: BASIC SOCIAL SERVICES AND WELFARE</u> FACILITIES

The objectives of any welfare service are outlined by Bessie
Touzel (i) as follows:

- "1) To assist any person who, because of material or social disability, is in need of economic or social aid, to reestablish himself as an independent, self-supporting citizen who can contribute his full share to the economic, social and political life of the community;
- "2) To work toward the prevention of circumstances that will create incapacity and dependency or will keep a person from contributing to the economic, social and political well-being of his community;
- "3) When re-establishment and prevention have failed to provide for the care and maintenance of those who, from whatever cause, are unable to care for and maintain themselves.

"Often care and maintenance programs without rehabilitation services of any kind, come first in time sequence, but reestablishment, where resources and skill allow, should be our first aim."

140. Miss Touzel emphasizes that the prevention of social problems is complex but possible. It requires the collaboration of many disciplines in the field of health and welfare as well as other specialists such as economists, labour and religious leaders, bringing their various skills to bear upon a common goal.

She points out as well that new techniques are developing through experimentation which should affect our concept of

prevention and social welfare and enable us to give greater emphasis to this objective in the future. She mentions the need for appropriate research and states that social welfare programs have suffered from lack of adequate examination.

141. In other sections of this report, the needs of the handicapped are listed in order of priority. Immediately following personnel requirements, reference is made to the absolute need for basic social welfare services. Actually these two priorities are related and indivisible. If children in general, and the handicapped in particular, are to receive the optimum in services, basic social welfare organization, using to the best advantage the comprehensive legislation now in effect in this province is of prime necessity. (1)

James S. Band, Deputy Minister of Public Welfare for

142.

fulfil, "

Ontario, states: (ii) -"In the immediate future there are several projects at the provincial level which point to significant changes, largely in the administrative and service aspects. Among the foremost is a proposal to consolidate the welfare services at the municipal level. The broadening of the local administrative services would replace the present splintered municipal base which has so far served Ontario under its local government authorities. It is conceivable that a country welfare administration under the jurisdiction of the county council would serve best at this stage of welfare development. Cities would probably retain their present economy. Such a consolidation of services for practical reasons is a project which will require several years to

- 143. It is readily recognized from the objectives as stated by Miss Touzel that the main purpose of economic or social aid is to rehabilitate the individual, to prevent social inadequacy. When both prevention and treatment fail; to care for those who are unable to care and maintain themselves. only then should we adopt the negative attitude toward social welfare. As is pointed out by Mr. Band, this approach will only come about through community organization. While the welfare provisions in this province by legislation are impressive and much money is spent, these have not been as effective as they should be because organization has been on a central and regional basis rather than as an effective community one. The activities of the central branch are divided into, a branch administration. However, some programs are applicable to all branches and will be dealt with in a general way.
- A. MANDATORY MUNICIPAL SOCIAL WELFARE SERVICES

  By the provisions of the Municipal Unconditional Grants

  Act 1959, municipalities are given a basic grant of \$2. per

  capita for the provision of welfare and social services.

  These include indigent unemployment relief, hospital and institutional care, and certain other services for the residents.
- 145. In addition for municipalities of over 2,000 population, per capita payments ranging from 10¢ for population from 2,000 to 5,000 to \$2.50 for metropolitan municipalities of over 750,000 population are paid by the province.
- 146. Effective in 1959, a grant of considerable size for indigent hospital care cost was made to each metropolitan

municipality, city, separated town in a county, to each county and to each municipality in the territorial districts.

- 147. Because these grants had been made available by the province, municipalities are required to provide certain essential services, which are as follows:
  - General Welfare Assistance for resident unemployed persons whether employable or unemployable and their dependents. The amount of these expenditures are governed by regulation.
  - 2) The Sanatoria for Consumptives Act Costs under this legislation are shared 80-20 by the province and the municipality. The purpose, to provide post-sanatorium assistance to needy persons on their discharge for convalescent care, if they are residents of the municipality.
  - 3) The Public Hospitals Act To provide and pay a statutory per diem rate for care in chronically ill, convalescent or general hospitals for indigent persons not in receipt of hospital benefits. If there is a difference between the statutory per diem rate under this Act and the per diem rate approved by the Ontario Hospital Services Commission, this is absorbed by the Commission. However, the municipality may pay the premium for hospital insurance for a group of indigents known as a "Collectors Group" under the insurance plan.
  - 4) The Child Welfare Act This Act makes provision for the municipality to underwrite the cost of care of children taken into care by the Children's Aid Society if these children are found neglected by the courts.

Forty percent of this cost is shared by the provincial Department of Welfare.

5) The Juvenile Family Court Act - This provides for sharing of costs of the upkeep of these courts. In the province there are 48 judicial areas. Provision is made also for the establishment and maintenance of a detention home for children under 16 years of age while disposition is being made of their cases.

#### 148. B. PERMISSIVE LEGISLATION

- 1) The Child Welfare Act The province will share with the municipality 40% of the cost of care given by Children's Aid Societies to children for whom it is needed although the children have not been made wards of the Society. It is necessary for the municipality to enact a bylaw empowering the society to furnish this type of care.
- 2) The Day Nurseries Act Under this Act the province will share the cost of municipally operated day nurseries.
  Fees may be collected from parents using these services.
- 3) The Homemaker and Nurses Services Act The province shares with the municipality the cost of providing homemaker and home nursing services, either under their own jurisdiction or those purchased from organizations approved by the minister of welfare.
- 4) <u>Dental Care for Children</u> This may be provided by a board of health and sometimes is restricted to those coming from low-income families. The province shares in the cost of providing this.

As stated previously, in addition to the various Acts
supervised by different branches of the department, certain
programs which apply to all these branches are administered as
follows:

#### 150. The Medical Welfare Plan

This Plan covers beneficiaries under Old Age Assistance,
Disabled Persons' Allowances, Blind Persons' Allowances,
Mothers and Dependent Childrens' Allowances, Rehabilitation
Services and General Welfare Assistance. Those in receipt of Old
Age Security may be included subject to a means test.

- 151. The Plan, which is administered by the Ontario Medical

  Association, is financed entirely by monthly contributions from
  the government on behalf of each recipient except those under the
  General Welfare Assistance Act for whom the province pays 80%
  and the municipality pays 20%.
- 152. Payment to physicians is made for services in their offices or at the patient's home. Provision is also made for the use of consultants when necessary, physician's services rendered in any nursing home or other institution except those approved by the Ontario Hospital Services Commission or as homes for the aged or charitable institutions by the Department of Public Welfare.
- 153. Emergency medication may be provided by the physician on first visit; subsequently the patient pays. If necessary, the patient can be given additional aid by the supplementary allowances provision under the General Welfare Assistance Act.

#### 154. Dental Care

Some provision has been made by the department as follows:

- i) An agreement between province and Royal College of Dental Surgeons provides free dental care for children under 16 years who are beneficiaries under Mothers and Dependent Children's Allowances Act. Provincial contributions are made to the College monthly.
- ii) Emergency extraction of teeth may be authorized by voucher of local welfare administrator. Account is payable on approval of deputy minister of health for those eligible under the General Welfare Assistance Act.

#### 155. Administration

As stated earlier, administration of department activities is by branch organization. These are:

Child Welfare Branch;

General Welfare Assistance Branch;

Welfare Allowance Branch:

Day Nurseries Branch.

Other branches make up the central organization but these will not be described as their activities are not predominantly or partially concerned with children.

In addition to the headquarters of the department in Toronto, regional and district welfare offices are located across the province at Alexandria, Barrie, Belleville, Chatham, Hamilton, Kingston, Kirkland Lake, Kitchener, Lindsay, London, North Bay, Ottawa, Port Arthur, Sault Ste. Marie, Sudbury, Toronto and Wingham.

- 157. These 17 regional and district welfare offices are headed by a regional welfare administrator. They work under the guidance of the director of Field Services Branch of the department.
- The field staff provides consultation to municipal welfare
  offices and give supervision to the administration of programs
  that come under provincial legislation. In the unorganized
  territories of Northern Ontario, they assume many local
  services because of the lack of municipal development.
- 159. In addition to the supervisory and consultation services,
  these regional offices process applications for Mothers and
  Dependent Children's Allowances and make payments in
  connection therewith. The field staff take applications and
  obtain all necessary information as to eligibility requirements
  for Disabled Persons' Allowances, Blind Persons' Allowances,
  Old Age Assistance and medical care for needy Old Age
  Security recipients.
- 160. The activities on behalf of children of the branches making up the Department of Welfare will be described. The Child Welfare Branch, since it is concerned with the activities of children's aid societies, will be explained in some detail since these provide the chief social welfare services in most parts of the province outside the larger cities. Services available for children from other branches have been summarized and are appended.

#### 161. The Child Welfare Branch

This branch supplies supervisory and consultant services and administers the provisions of the Child Welfare Act, the Charitable Institutions Act and the Children's Boarding Home Act. This consists of the visits of field workers to the various institutions and societies, interpretation of new regulations, assistance to societies and institutions on matters of policy, administration and organization, and encourages co-ordination and exchange of information relating to child welfare.

- An adoption clearance service is provided to collect information on children who need parents and where these parents may be found. This applies more recently to the matter of the adoption of handicapped and older children.
- 163. Registration and the supervision of standards for private boarding homes caring for five or more unrelated children, other than those foster homes and institutions operated by children's aid societies, and homes, hospitals or institutions covered under other provincial legislation, is an additional function. Specifically the duties of this branch, as related to the different Acts of Parliament are as follows:

#### 164. l. Children's Aid Societies

In the province there are 55 children's aid societies.

These possess official powers and have privileges similar to a voluntary agency. Their official powers extend to matters of child protection and adoption and they are organized only with the consent of the Lieutenant-Governor in Council. They are under the supervision of the

Department of Public Welfare and finances, for the most part, come from public funds originating with the province or the county or local municipality. The societies have the power to collect for the maintenance of temporary or permanent wards from the municipalities and parents by law may be ordered to pay for part or all of the cost of care. Where wardship has not been given to the society but a child is provided with care or shelter, municipalities are liable for the cost of this care. Forty percent of this can, in turn, be collected from the province by the municipalities. As voluntary agencies, the activities of the societies are governed by citizen boards and they operate as non-profit charitable organizations. Under the Ontario Corporations Act the societies are authorized to use private donations to provide extra services not covered by statute.

- 165. The activities of the societies can be listed as follows:
  - The protection of children This can be classed as a) a preventive service in the child's home to determine whether or not physical or emotional neglect is occurring. In general, every effort is made to keep the child in the home and to improve the family situation or relationship. If this does not result, then the child can be taken as a ward. Temporary care or shelter for a non-ward in an emergency also is possible.
- 166. Neglected children, as defined under the Child Welfare Act - Children not being properly cared for, deserted, or those living in unfit or improper places, associating with unfit or improper persons, or those who are delinquent

or incorrigible because of lack of supervision by the person caring for them, may be removed from their homes by the society. Neglect extends to and includes emotional rejection or deprivation of affection which in the opinion of a psychiatrist is considered as likely to interfere with emotional and mental development. Temporary or permanent wardship of a neglected child can be awarded by a court to the society and thereafter it is responsible for care. The rights of the individual are protected by the stipulation that the child must within ten days of coming into custody be brought before the family court.

- 167. Temporary wardship designed to allow the societies to improve the home and family situation can be given to a society for up to two years. At the end of this time if he cannot be returned to the home, permanent wardship results. Permanent wardship is on occasion vested in the society if the child is without parents or where it is considered that home conditions will not make it possible for the child to be cared for by his parents. In this case it can be obtained by the society early.
- Depending on the child's needs, temporary wards are cared for in foster homes, receiving homes, correctional institutions or in hospitals. Permanent wards are cared for by adoption in addition to those mentioned above, if this can be arranged and the child is suitable.
- 169. c) <u>Unmarried Parents</u> Protection and advice are provided on application of the mother for children born out of wedlock.

Regulations provide that garnishee proceedings may be used to enforce an affiliation order against a putative father.

- d) Adoption Adoption is possible for those under 21

  years of age after the director of the Child Welfare Branch

  has certified that the child has been in residence for at least

  six months with parents that are considered by him as suitable.
- Applications for adoption must be made to a court. In the case of an unmarried mother, written consent must be obtained after the child is seven days old. If the child resides with the father, then he must furnish this. Consent may be withdrawn by a parent within 21 days after being given by the submission of a written document.
- e) <u>Family Services</u> Because as stated earlier, the
  Children's Aid Society is usually the only official agency
  concerned with social welfare, many societies are now
  providing advice in dealing with social problems. This is
  not restricted to any age group and often is not associated
  with any neglect of children.
- 173. f) Social Action This is an educational function in the community to improve the facilities for child life.
- 174. 2) <u>Institutions for Children</u>

The provision of orphanages and other institutions caring for homeless children has been replaced by the development of foster home programs, adoption and by the provision of mothers' allowances.

- 175. In recent years many of these institutions have changed their programs to provide specialized group care services for the purpose of returning children to normal community life.

  Under the Charitable Institutions Act which is supervised by the Child Welfare Branch, there are in existence 44 institutions 28 for children, 12 for unmarried mothers and infants, one receiving home for girls, one industrial refuge for girls and two homes for young discharged male offenders. These institutions provide care for approximately 6,000 persons, of whom 75% are children. The purpose of the Child Welfare Branch is to supervise these and to help in improving services.
- 176. Financial aid is given by the province under the Act amounting to \$8. monthly per child, and in addition grants are made toward the cost of new construction or additions, or the purchase of buildings. These grants are the lesser of \$2,500. a bed or 50% of the purchase price of existing structures.
- 177. Regulations under this Act set out standards as to the physical facilities, social case recording and the requirements for planning each child's future. Educational standards are outlined and staff requirements are designated. Under this Act each institution must appoint a physician and a nurse.

## 178. 3) Boarding Homes for Children

This Act, supervised by the Child Welfare Branch, provides for minimum standards of care and the aids to assist in physical health and safety of the residents. It applies where five or more children not related to one another through a parent, a step-parent or grandparent, are lodged, boarded or

cared for. Where other provincial supervision is exercised through legislation, exception to the regulation is made. This applies to homes or institutions supervised by the Child Welfare Act, the Mothers and Dependent Children's Allowances Act, the Day Nurseries Act, the Maternity Boarding Houses Act, the Charitable Institutions Act and the Private Hospitals Act

physical living conditions, health and safety measures, the
maintenance of records and reports and staff. Penalties are
provided for non-compliation with the Act or Regulations.

# 180. Social Service Activities of Other Ontario Government Departments

Most Ontario governmental departments contribute directly or indirectly to social welfare services in the province. In addition to those of the departments of health and education which are described in some detail, these can be summarized briefly by department as follows:

#### 181. The Department of the Attorney General

1) Juvenile and Family Courts - Jurisdiction governing the activities of these courts is divided between the federal and provincial governments. Under the Juvenile Delinquents Act (Canada) and provincial legislation, juvenile and family courts since 1954 have been combined. They now have power to enforce maintenance orders previously made by the supreme court. Privacy relating to the airing of family matters in court is therefore possible.

- At the present time there are 46 of these in the province serving counties, groups of counties or a district in an organized territory. Only two judicial jurisdictions have not established these specialized courts.
- 183.

  2) The Probation Branch Over 140 provincial probation officers are attached to the criminal courts of the province.

  In addition, there are about 40 employed who work only in juvenile and family courts. Only one of the 48 judicial areas is without the services of a probation officer. Probation offices supply two main services:
  - The supplying of pre-sentence reports and social history of the person before the court on request.
  - b) The supervision of persons placed on probation.

    Thôse officers attached to and serving the juvenile and family courts exclusively, supply service in cases of marital conflict as a preventive service before any actual charge is laid.
- 184. 3) The Official Guardian Since 1950, the official
  guardian has been empowered to report on, after investigation,
  "all matters relating to the custody, maintenance, etc., of
  children under 16 whose parents are involved in a divorce
  action." He is expected to assist in the dispensing of
  justice by furnishing impartial reports to help the courts make
  the best decision as to the custody of children. Where divorce
  is not a factor in non-divorce custody actions, these reports
  are similarly made for the same purpose.
- 185. The official guardian enlists the services of children's aid societies on a fee basis to do the investigation and make the

report. As can be appreciated, staff limitations on the part of children's aid societies, either as to training or numbers, will restrict the value of such investigations and reports.

- 186. 4) The Public Trustee It is of interest that the public trustee is the representative of charitable interests before the courts. It is his responsibility to make sure that trustees for unnamed charities carry out their duties in accordance with the law.
- 187. The Department of the Provincial Secretary and Registrar General

This department is responsible for the Vital Statistics Act, among others. Because of this fact, other official agencies are often handicapped in the matter of receiving vital statistics information which would be of value particularly in the matter of registration at birth of handicapping conditions in children. While these eventually are obtained by the Department of Health, the condition is reported, not the person suffering the disability. In general provincial registrars at the community level are most co-operative in supplying information that may be of value to local official agencies but they do not have to comply with these requests which contributes to ineffective reporting.

Another division which is important in social welfare is the citizenship division under this department. The purpose of this is to assist in the reception of immigrants; to give information and make referrals; and to bring about the overall co-ordination of provincial government services to immigrants.

- Department is activities in connection with the Alcoholism

  Research Foundation. The objectives of this body are to conduct and to promote a program of research in alcoholism; to conduct, direct and promote programs for treatment of alcoholics and rehabilitation of alcoholics; to develop experimentation and methods of treating and rehabilitating alcoholics; and to disseminate information respecting the recognition, prevention and treatment of alcoholism. The Foundation is under the direction of eleven board members and a medical advisory board of 10.
- 190. At present activities have been established in Toronto and are planned or are operating in London, Ottawa and Hamilton. A treatment service is available in Toronto including general medical, psychiatric, psychological and social work services. Emergency medical care can be arranged for in general hospitals and convalescent in-patient care in the Foundation's own hospital for those in need of more intensive treatment. Out-patient services are available for follow-up patients discharged from hospitals or those not requiring in-patient care.

#### The Department of Municipal Affairs

Since this department is concerned with community planning under the Planning Act 1955, a contribution is being made to the provision of improved living conditions in new subdivisions, the provision of planning standards and studies on regional development.

192. Urban renewal is contributed to by the provincial contribution of 25% of the cost of acquiring and carrying areas designated for re-development and the supplying of advisory service on urban renewal programs and practices.

#### 193. The Department of Planning and Development

One important activity of this branch deals with the Housing Development Act which is related to grants-in-aid for building development, the guarantee of housing loans, and the financial assistance in residential building developments and federal government and municipal public housing projects.

#### 194. The Department of Reform Institutions

This department, because of its jurisdiction over jails, reformatories, industrial farms, treatment centres, training schools and female refugees is involved with social welfare activities affecting the age groups with which this survey is concerned. Treatment, academic and vocational training for offenders between the ages of 16 and 25 years who have the greatest potential for reformation, is provided in the training centres and Burtch.

- 195. A training school for boys 14 years and under is operated by the Department at Cobourg. Another for boys 14 to 16 years is provided at Bowmanville. A training school for girls under 16 is located in Galt, and an open residence for girls at Port Bolster.
- 196. The department gives supervisory services to three institutions operated under Roman Catholic auspices. These are located at Alfred, Uxbridge and Downswiew. The first

two are for males and the last for girls. A training school advisory board of five members meets weekly to review reports on programs and training and to decide on placement and termination of wardship.

#### 197. The Department of Labour

The main program of this department in social welfare is that activity under the Workmen's Compensation Act. The provision of compensation payments representing 75% of average earnings over a four-week period prior to the accident; disability pensions and lump sum awards or pensions to widows; payments made on behalf of dependent children or orphaned children up to 16 years of age, does much to ensure the maintenance of family life.

- In addition to the services available to Ontario residents
  through the Department of Welfare and other branches of
  government, the federal government contributes a large amount
  of money and service to the citizens. This has been done
  despite the fact that social welfare in Canada has been
  historically a responsibility of the province. This
  participation has been possible without amendment of the
  British North America Act.
- 199. Previously, this participation has been outlined in brief or in detail and this will not be repeated except in those cases where services or payments are made direct. This will be done by the different departments of the federal government.

- 200. The Department of National Health and Welfare Welfare Branch
  The major contribution is in the matter of family allowances
  under the Family Allowances Act 1944. This provides for cash
  allowances to be paid to the mother of every child under the
  age of 16 years born in Canada. If the child was not born in
  this country, he or she must be a resident for a period of one
  year unless his father and mother had residence for three years
  immediately preceding his birth.
- 201. The allowance is \$6. for each child under 10 years and \$8. for each child from age 10 to 16. The allowances are paid by cheque to the mother of the child in most cases. These may be paid to child-placing agencies on behalf of the children in care but are not paid to institutions. All recipients must comply with the Provincial School regulations. Allowances are not paid to any girl who is under 16 years and married. Allowances are not paid outside the country.
- Eskimo and Indian children are eligible and in certain of these situations, in lieu of allowance, nutritive foods are dispensed rather than cash. Administration is by a national director of family allowances through regional directors located in each provincial capital. Investigations as to the abuse of family allowances are ordinarily made by the staff of local children's aid societies.

#### 203. Health Grants

National health grants were introduced in 1948 and indirectly contribute to the social welfare of the residents of the province. Part of these grants are used for the improvement and strengthening of provincial services relative to crippled

children, public health research, venereal disease and tuberculous control, mental health, cancer control, professional training and general public health. In 1953, additional grants were established for the development of services in the field of maternal and child health and medical rehabilitation. Training grants have been available for medical social workers among others.

#### 204. National Hospital Insurance

Grants are made to the province under the Hospital Insurance and Diagnostic Services Act, 1957. In general, these grants are applicable to half of the provincial cost for in-patient services and emergency out-patient benefits. The level of in-patient service is standard ward hospital care and auxiliary services necessary for both in-patients and out-patients in general, chronic and convalescent hospitals. Mental hospitals and T. B. sanatoria are excluded.

#### 205. The Department of Veterans' Affairs

Under the War Veterans' Allowance Act, children receive certain benefits indirectly through payments made to parents or as orphans of veterans.

#### 206. The Indian Affairs Branch

In Ontario this branch operates 11 residential schools with an enrolment of more than 1,500 children, 98 day schools for almost 5,000 children, 18 seasonal schools for more than 500 children and two schools in hospitals for 73 children. Contributions also are made to 12 joint schools attended by 800 Indian pupils,

207. In Southern Ontario there are 13 Indian Agency offices and
 10 are located in Northern Ontario. Through these offices
 more than 40,000 Indians receive services; 164 Indian
 Reservations have been set aside throughout the province.

#### 208. The Department of Labour

In addition to the operation of the Unemployment Insurance
Act, this department operates the National Employment
Service. In regard to children, specialized attention is
given to the needs of:

- Young persons whohave not become established in industrial or business life;
- Employable applicants who suffer from physical and mental handicaps;
- Persons wishing to undertake apprenticeship or other types of training courses.

#### 209. Civilian Rehabilitation Branch

This was created in 1952 to develop a co-ordinated national program for the rehabilitation of disabled persons. A National Advisory Committee on the rehabilitation of disabled persons was established representative of all the provinces, the medical profession, voluntary organizations in this field, organized labour, management and the universities. This committee advises on the development of the program. It works closely with the provincial rehabilitation co-ordinator and supplies consultative and advisory services as required. Matters relative to salaries, travelling expenses and other disbursements which are shared between the federal and

provincial governments as these apply to rehabilitation in all its forms, is administered by the branch.

- 210. Another function is the administration of Schedule "R" of the Canadian Vocational Training Co-Ordination Act. Under this legislation, costs of vocational training for disabled persons and maintenance and transportation associated with such training, is shared with the province.
- 211. The Medical Rehabilitation Grant is available to help the provinces cover the cost of training medical personnel in regard to rehabilitation duties, buying of medical rehabilitation equipment and the sharing of cost of expanding or purchasing services. In addition, consultative services are provided to the province on medical rehabilitation problems.
- 212. Outside the country close contact is maintained with similar officials in the United Kingdom and the United States. On the national level, liaison is provided with the International Labour Organization, the Rehabilitation Section of the Division of Social Welfare of the United Nations Organization and the International Society for the Welfare of Cripples.

#### 213. SUMMARY

The purpose of welfare services has been well defined by Miss Bessie Touzel, executive secretary of the Ontario Welfare Council. The objectives can be listed in order of priority as rehabilitation and prevention. The provision of care as a by-product of failure of providing such services then becomes necessary.

- 214. 2) Administration, which is now on a regional basis,
  must be decentralized to the community as represented
  by a county administration. The deputy minister of
  welfare has indicated that this change will take place in
  the immediate future.
- 215. 3) Welfare services possible by legislation in Ontario are impressive. However, these are not being used to the best advantage because of the emphasis that is placed on dealing predominantly with end results rather than prevention and rehabilitation.
- 216. 4) Lack of personnel or improper deployment of those
  available and trained, contributes to the inadequacies
  observed. Social service training programs based on
  a realistic need of the services to be performed should
  be established by universities.
- 217. S) Where an attempt has been made to provide more inclusive service under a single administration as, for example, Peel County (iii), the results have demonstrated the value of this type of program.
- 218. 6) Welfare services available by the provincial and federal departments of welfare and other departments of the federal and provincial governments are described.

#### 219. REFERENCES

- (i) Ontario Welfare Council the Province of Ontario -Its Welfare Services - Third Edition - 1960 - P. P. XV
- (ii) Ibid P.O.VI
- (iii) Bessie Touzel Welfare Services in Peel County -1954 - P.P. 45

each additional

### 220. WELFARE ALLOWANCES BRANCH

		ANCIA TICIP		ON	CASE LO	AD MONT	HLY GENERAL
LEGISLATION	Fed.	Prov.	. Mu	n. ELIGIBILITY	1959	ALLO	W. ELIGIBILITY
Blind Persons Allowances Act 1951 Amended 1958	75	25	0	-Less than 20% vision -Over 18 years -10 years' reside in Canada	1833 all ages nce	\$ 55.00	-Medical, hospital care Supplementary allowances under -General Welfare assistance -Rehabilitation services with C.N.I.BIncome limitations \$1,200., \$1,980., \$2,100.
Disabled Persons Allowance Act 1955	50	50	0	-Permanently and totally disab: -Over 18 years -10 years' resider in Canada		\$ 55.00	-Medical and hospital care -Supplementary allowances under General Welfare Assistance -Medical Advisory Board approval -Income fimitations \$960.,\$1,620.,\$1,980.
Rehabilitation Services Act 1955				-Handicap prevent remunerative employment -Residence in Ont for 1 year		single \$115.00	-Medical and hospital care -Flexible income -Regional application & approval, follow-up, counselling -Advisory committee of five
Mothers and Dependent Children Allowances Act 1957				Mother  -Husband permanently unemloyable  -Husband deserted 6 months  -Divorce custody  -Husband imprisor 6 months or more  -Child born out of wedlock to mothe 18 years or over Father  -Unemployable widower	fathers ned	to	-Indian mothers included -Allowances paid until children reach 18 years -Allowances calculated on needs of family related to income & resources. Part-time employment encouragedLiquid assets of \$1,000. for applicant with one dependent, \$200. for

-Deserted

-Wife in institution -Medical. dental and -Wife prisoner hospital care Foster Parents \$30.-1 \$55.-2 -Close relatives -Residence - 1 yr. \$15. -for each additional 221. GENERAL WELFARE BRANCH FINANCIAL PARTICIPATION CASE LOAD MONTHLY GENERAL LEGISLATION Fed. Prov. Mun. ELIGIBILITY 1959 ALLOW. ELIGIBILITY General 50 30 20 -Those in need whether Heads of -Applicant must Welfare unemployable or not Varies Families register with Assi stance -12 months' residence \$120.-1 N.E.S. Act 1958 in municipality -Medical, Dep. otherwise previous \$180. emergency denresidence is 6 or tal, hospital care charged more -Nursing home dep. care in licensed premises -85% of benefits under O.A.S., O.A.A., Blind or disabled taken into account. -Supplementary assistance for high rentals, costly drugs up to \$20, monthly -It is mandatory 0 80 20 for municipality to furnish assistance. Failure to do so results in province assuming responsibility & charging municipality for its share of costs. 50 -Liquid assets Homemakers 0 50 -Maximum provincial contriless than \$1,000. and Nurses plus \$200. for each bution Services dependent -\$4. for 8-hr.day Act, 1958 -Physician's or 50¢ hour certificate of need -\$1.25 for each nursing visit -Qualifications of homemaker

defined

-Nurses registered under Nurses Reg. Act. 1951

#### THE DAY NURSERIES BRANCH 222.

#### FINANCIAL CASE LOAD LEGISLATION PARTICIPATION ELIGIBILITY 31 Mar, 1958 GENERAL (all nurseries)

The Day Nurseries Act	Provincial Grants to Municipalities	Working Mothers	-9,000 children in attendance at 11-half day 16-full day Nurseries	-Inspection by municipal fire and health authorities -30 Square feet indoor play space per child -60 Square feet outdoor play space per child -Proper standards of health care and nutrition -Program must conform to approved methods of pre-school guidance
	N.A.	N.A.	-256 other Nurseries	Administration  128 - Operated by individuals  51 - Co-operatives 85 - Private agency 19 - Public agency

SECTIONS 6, 7, 8 and 9 supplementary to Appendix #10, received subsequent to original printing and included to complete this report

#### 223. SECTION SIX: EDUCATION

The principle of education being supported by public funds has been in effect in this province for over one hundred years. This program has accomplished in general the original purpose, namely, the prevention of illiteracy. This report is concerned primarily with the problems of the handicapped child. While it could be argued that these cannot be restricted to those with obvious disabilities but rather should include those who normally have adequate physical and mental capacity but who are experiencing difficulties, the problem imposed would be of such magnitude that it might well and should form the basis for a separate report.

#### 224. Administration

Normally, education is governed and controlled by several Acts. These are:

- 1. The Department of Education Act
- Public Schools Act
- Separate Schools Act
- 4. Secondary Schools Act
- 5. Schools Administration Act

These acts provide for both permissive and mandatory programs being developed across the province and in general are amplified by regulations which may refer to some particular phase or aspect of the broad technical and administrative provisions.

#### 225. Educational Development

The development of education has been based on the principle of

local administration. The most fundamental units of this would be a Board of Education composed of three elected persons administering the affairs of a one-room school. All education developed from this basic unit. The Provincial Department of Education exercises supervision by these Acts and Regulations, supplies funds in the form of grants, and supervision through inspectors.

226. There are many voluntary associations concerned with education.

At the local level there are Home and School and Parent-Teacher groups. At the Provincial level there is the Ontario Educational Association which through its various branches or divisions provides the medium for trustees, administrative officers, inspectors, principals, teachers and others to conduct research and otherwise contribute to the advancement of education by submissions to the Department and/or local board.

#### 227. The Education of Handicapped Children

This comes under the Auxiliary Education Services Branch of the

Department and provides for either classes or units. These names are
self-explanatory in that a class refers to a group of pupils whereas a
unit refers to the facilities supplied for one child. These extend to
and include opportunity classes and units, limited vision classes and
units, orthopaedic classes and units, elementary home instruction
units, secondary home instruction units, oral classes for the deaf,
hard of hearing classes, health classes, and gifted classes. In
addition, for those unable to attend schools, there are home instruction
teachers. Working in more than one school there are speech
correction teachers and itinerant auxiliary teachers.

- 228. In addition, the Department operates two schools, namely, the
  Ontario School for the Blind situated in Brantford and the Ontario
  School for the Deaf located in Belleville. A report on these is
  attached in the appendix. An additional school for the deaf is being
  built in Milton.
- 229. These programs are administered by a superintendent of the Special

  Educational Services Branch. This Branch has three main divisions
  each under a director, namely:
  - i) Auxiliary Education Services
  - ii) Guidance Services, and
  - iii) School Attendance
- 230. The report of the Department (i), emphasizes that auxiliary classes are being developed in more and more small urban and rural areas and are providing service. This is in contrast to the previous situation where they were only thought feasible in larger urban areas.
- 231. The activities of the staff are stated to be concerned with:-
  - Organizing and conducting surveys in areas where it was contemplated establishing services for exceptional children.
  - Working with teachers and inspectors in rural areas for the purpose of planning suitable school programs for children with learning difficulties.
  - Working with teachers and inspectors regarding special class programs.

The staff of the Branch participate in numerous in-service training programs for teachers on special education topics. These extend to not only special classes, but also atypical pupils in regular grades.

#### 232. Library

A library of magni-type books to assist pupils with limited vision as well as a professional library for the use of teachers and inspectors is maintained whereby books can be obtained on loan free of charge.

#### 233. Teacher Training

Certificates in auxiliary education are obtained through summer courses leading to elementary, intermediate and specialist certificates. The Report states that 509 were enrolled in the previous year which was an increase over the previous year. To cover the various phases of exceptionality, eight different options were offered, and an increasing number of secondary school teachers were enrolled in the auxiliary education and secondary schools option.

## 234. Education for Retarded Children

As an example of the interest and flexibility of the Department of Education, the program for trainable retarded children is outstanding. This is relatively recent in that it was commenced in 1953 and has increased until at present over 70 schools for the retarded are now in operation in the province. Instruction is provided for over 2,000 children. Financial support is supplied through grants not only for school purposes but also for approved capital expenditures on buildings.

- 235. To reconcile the educational facilities available for handicapped children, it is best to relate these to the medical and social condition that may be encountered in the handicapped.
- 236. (1) Acutely Ill and Convalescent Children: Children can receive education in hospitals during the convalescent stage of an acute illness by classes established under a Board of Education of 3 persons.

The Department of Education makes grants towards the salary of the teacher or teachers and certain other expenses concerned with the operation of these classes.

- 237. (2) Chronic and Long Term Illness: Again, classes may be
  established under a Board of Education for the hospital or these classes
  established in the hospital or institution can come under the authority
  of a Board of Education for the municipality in which the institution
  or hospital is located. Similar grant arrangements will be made
  depending on the administrative set-up.
- 238. (3) Treatment Centres: In some of the treatment centres educational facilities have been provided and the same administrative and grant set-up is available.
- 239. (4) Home Instruction: These usually apply for children who are discharged from hospital but who physically are not able to return to a special or ordinary school. In this case home instruction teachers can be made available by the Board of Education of the municipality or elementary or secondary home instruction units can be obtained through the school inspector so that the child's education can be continued.
- 240. (5) Special Classes for Particular Conditions: This would include oral classes for the deaf, hard of hearing classes, limited vision classes, and orthopaedic classes. These can be established as part of the ordinary school system, where certain classes are established in existing schools or are set up as individual schools. These provide

instruction for children separately from ordinary instructional facilities. Only in the larger cities are special schools in operation. In general, the policy would appear to be not to isolate these children from ordinary class instruction where possible. Segregation of these handicapped children is not ordinarily recommended and furthermore, often the numbers are not large enough to justify the setting up of separate facilities.

- 241. (6) Health Classes: This is a distinct group restricted to children who, because of sub-normal health, are provided with instruction in a situation where extra rest periods and supplementary foods can be given to the child to raise their health level to the point where they can return to ordinary classroom instruction. Again, these are not found except in larger centres and the numbers of these classes are decreasing.
- 242. (7) The Slow Learning Students: Very early in the survey in discussions with school administrators, it was emphasized that the problem of the slow learner was of greater magnitude than that of the physically handicapped child. Ordinarily instruction for these students is provided by opportunity classes and units. However, there is a group of students with an I.Q. of from 75 to 90 who require educational facilities less restricted than those given in the ordinary opportunity class where the I.Q. level is from 50 to 90. Several Boards of Education have done a good deal of work in meeting this problem and it would appear that the results justify the time and high quality of teaching involved. It is apparent that the educational authorities at both the Provincial and the local level are alert to this problem and are attempting to meet it.

- 243. (8) Opportunity Classes: As stated previously, there has been a great increase in the creation of these facilities and a corresponding increase in the number of teachers taking summer courses to improve their qualifications. The policy of the Special Services Branch is to establish more of these facilities in smaller cities and towns across the province. The limiting factors have been the lack of interest displayed by boards of education or trustees, a lack of teachers with the necessary educational qualifications and too few inspectors.
- (9) Trainable Retarded Children: The increase in facilities for the 244. training of these unfortunate children has been phenomenal. This program was started in 1953 and at the present there are over 70 such schools in the province with an attendance of over 2,000 children. The social and economic benefits accruing to all concerned and the relief of pressure on institutions previously providing custodial care, can hardly be estimated. The affairs of these schools are directed by local branches of the Ontario Association for Retarded Children which are predominantly made up of parents of these children. However, the purely educational features are under an education committee made up of interested appointed persons from the community along with the school inspector and the Medical Officer of Health. Admittance is restricted to those children with an I.Q. of less than 50 with the lower limits of intelligence not specified but in actual practice related to whether or not the child can profit by instruction.
- 245. (10) Gifted Classes: The increase in the number of these have been remarkable, increasing from two in 1953-54 to 37 in 1960. As the title suggests, the purpose is to provide an enriched type of education.

and in doing so to avoid a gifted child becoming bored doing tasks which do not challenge his superior intelligence.

246. (11) Speech Correction and Itinerant Auxiliary Teachers: There has been a marked increase in the number of teachers devoting their time to speech correction. Ordinarily they divide their time between several schools in a system large enough to provide a sufficient number of students requiring instruction. Itinerant auxiliary teachers are employed where the number of students in any one school is not sufficient to justify the setting up of a class.

#### 247. Financial Assistance to Boards of Education

It is recognized by the department that for special classes, a smaller number of students will be placed under the direction of a teacher. For this reason, the size of the grant per student is increased so that the actual cost of operation to the local taxpayer is not out of proportion to the charge for the education of a child in the regular school system.

#### 248. SUMMARY

A brief description has been given of the educational facilities available for the handicapped in the broadest meaning of the term. The facilities and financial assistance provided by the Department of Education and local boards has been mentioned.

249. There was little indication during the survey that the needs of all children were not being met across the province. Where this was a factor it was due primarily to a lack of interest on the part of a Board of Education or because the numbers of children involved was too small

to justify the creation of these facilities. However, provision for these children, either in the regular school system or through instruction units, made it possible for most of those desiring education to obtain it.

250. The two special schools operated by the Department of Education, namely, the School for the Deaf at Belleville and the School for the Blind at Brantford, are described in the appendix. These are excellent schools, well organized and conducted, and are providing valuable education not only for students of the province, but some from outside as well. It is significant that the School for the Deaf in Belleville was first under the superintendency of a medical doctor and the School for the Blind in Brantford was under the Department of Institutions with the emphasis on custodial care. The recognition by those concerned that the needs of these children were predominantly educational rather than treatment or custodial, is significant. It is apparent that the same thoughtful consideration should be given when any school facilities are provided. Essentially this resolves itself into which department of government should supervise these special facilities. On the surface it would appear that there should be little or no conflict and this should be entirely related to what the prime need of the child is at any particular time. Fundamentally, most children can profit by instruction, therefore, it would appear that a child should be under the supervision of the educational authority when treatment has reached the end of the convalescent period.

<sup>(</sup>Reference: (i) Ontario Department of Education - Report of the Minister, 1960)

#### 251. RECOMMENDATIONS

- 1. The almost universal adoption of the consolidation of schools in the province has resulted in improved educational facilities for the average child. It is recommended that the unit of administration for special services should be on a larger municipal basis, preferably the county system. This is dictated by the numbers of students involved in the average jurisdiction of a Board of Education and the numbers of instructional staff available.
- Additional inspectors are required to supervise the activities
   of special services facilities.
- 3. Vocational planning and guidance for handicapped children must be more intensive and different from that provided for the average child. Emphasis must be related to vocational and other goals, for example, recreation.
- Close co-operation between those supplying the educational needs and those concerned with the physical and mental needs of the child is most important.
- 5. Educational facilities and personnel are essential for not only
  the physical but the emotionally or mentally handicapped student,
  as well. The emotionally disturbed child is recognized as
  constituting up to 10% of the school population.

## 252. ONTARIO SCHOOL FOR THE BLIND (Appendix A)

Location: six main buildings in 45-acre park in northwest section of Brantford, a city of 52,000 persons.

The main administration building was built in 1872, but a new Junior School, including dormitories and hospital, and which cost approximately \$1,250,000., was built in 1953. In October 1960, four new classrooms attached to the Junior School were put into operation.

On May 11, 1961, a new wing, including an auditorium, music studios, practice rooms and a gymnasium (approximate cost \$640,000.) was officially opened.

- Enrolment: October 15, 1961 236 students 137 boys, 99 girls.
   177 Ontario, 9 Alberta, 24 Saskatchewan, 19 Manitoba, 4 Quebec,
   2 Northwest Territories, 1 Peru.
- 254. Staff: Total staff, including casual workers on a regular basis is 120.32 are teachers, 19 houseparents.
- 255. School Year: Begins on the Thursday following Labour Day and ends
  on the third Thursday of June, with approximately eighteen days off at
  Christmas and eleven and a half days off at Easter.
- 256. Program: The program of study is based on the Provincial Courses of Study for Grades 1 to 12, leading to a four option Secondary School Graduation Diploma. Subjects such as Home Economics, and Handcrafts for girls, Manual Training and Piano Tuning for boys, and Typing for both are practical courses begun as early as Grade VI and continued through Grade XII.

- 257. An active and varied physical education program, both indoors and out, having full regard for the individual abilities of the students, is provided. An annual track meet is held with the New York State School for the Blind of Batavia, N. Y., with the locale alternating between the two schools. A full music training program consisting of vocal, choral and instrumental work gives each child the opportunity to develop his talents. Usually, about eight students each year try examinations with the Royal Conservatory of Music in Toronto regularly reaching Grade 8 standard and with occasional students achieving Grade 10 and A.R.T.C. Recreational activities include Girl Guides, Boy Scouts, Wolf Cubs and Brownies, as well as senior clubs for social activities and the operation of snack bars. A wide variety of community activities are attended by the students.
- 258. Ten students graduated from Grade XII in June 1960 and nine in June 1961. Of these, nine are presently attending universities, three are training to be home teachers for the blind, one is taking the dictaphone typing course and two are studying beyond the Grade XII level in their own local High Schools.
- 259. The medium of instruction at the school is braille. Visually handicapped children with sufficient sight to use ink print are encouraged to remain in their own home school.
- 260. Fees: Fees paid on behalf of non-resident pupils by respective provinces, are \$1,000. per annum.
- 261. Cost of Operation: For fiscal year 1960-1961

Salaries: \$375,936.46 Maintenance: \$98,426.32

Travel: \$2,539.44

TOTAL: \$476,902.22

#### 262. ONTARIO SCHOOL FOR THE DEAF (Appendix B)

The school is entirely residential and serves children of the whole

Province of Ontario except those eligible to attend special day

classes in larger cities, such as Toronto and Ottawa.

Age of Admission: 5 to 6 years, depending on accommodation.

Enrolment: October 15. Boys 292, Girls 251, Total: 543.

Terms of Admission: Parents must be resident in Ontario. Child must be deaf or severely hard-of-hearing. Child must be mentally ready for school program (mental age of 5 years approximately.)

Fees: None, except in case of Treaty Indians for whom Federal

Fees: None, except in case of Treaty Indians for whom Federal Government is responsible and pays \$1,000. per year.

Cost to Parents: Must supply clothing according to school list.

Personal incidental expenses of child - \$15. to \$25. per year.

Cost of transportation to and from school at summer, Christmas and Easter vacations. Note: Provincial Government pays cost of return rail fare above \$6. for child under 12, and above \$12. for child 12 years of age and over.

Staff:	Educational staff - Teachers, Supervising Teachers,	
	Superintendent:	77
	Residential staff - houseparents:	35
	Kitchen, dining room, and cleaning staff:	50
	Laundry staff:	6
	Medical and Infirmary staff:	5
	Engineering, caretaking, maintenance, transport,	
	staff:	_29
	Total:-	202

School Year: September to June - 180 school days approximately.

### Courses Offered:

Academic - up to and including Grade X. Includes preparation for writing admission examinations for entrance to Gallaudet College, Washington 2, D.C., the only college for the deaf in the world.

Vocational - Girls - beauty culture, home economics, sewing and dressmaking, typing and business machine operation, laundry work.

Boys - carpentry, drafting, horticulture, metal trades (sheet metal, welding, lathe work,) printing, woodworking.

Placement of Graduates in Employment: Placement Officers of the Canadian Hearing Society, 2 Bloor Street, East, Toronto, in cooperation with the Guidance Department of the school, place all graduates needing assistance in employment.

Teacher Education: Teachers join staff qualified as Elementary or Secondary school teachers in Ontario and spend first year on staff taking full time course leading to Specialist Certificate as Teacher of the Deaf. The course is provided at the school and is staffed by the Superintendent, Audiological Services Adviser, and 4 instructors in professional training (all 6 of whom have other duties as well.)

Observation and practice teaching are carried out in classes at all levels in the school.

Cost of School Operation: Fiscal year 1960-61:

\$ 735,563.92 - Maintenance 294,869.57 - Salaries \$1,030,433.49

French Language Instruction: The language of instruction of the Ontario School for the Deaf is English. Where an Ontario child comes from a home where only French is understood, the Ontario Department of Education pays the tuition fees for the child to attend one of the two French schools for the deaf in Montreal.

- 263. SECTION SEVEN: REGISTRIES FOR HANDICAPPED CHILDREN

  It is now ten years since the report of the Ontario Health Survey

  Committee was released. (i)
- 264. In the section of this report dealing with handicapping conditions in children, it was stated;

"There is a great deal of valuable work being done under the auspices of governmental and voluntary agencies but there would also appear to be a lack of co-ordination which tends to decrease the effectiveness of their respective efforts. For example, neither the voluntary organizations nor the Provincial Department of Health can tell how many children with handicapping conditions there are in Ontario, nor what proportion of the total is receiving some assistance. The establishment of an efficient system for registering, classifying and following up such cases discovered anywhere in the province would seem to be a prime need."

- 265. Among the recommendations made for handicapping conditions in children and actually appearing as the first recommendation was that:-
  - "(1) A central registry be maintained to which all agencies in the field of public health shall be required to report discoveries of handicapping conditions in children.
  - "(2) In areas which have public health services, discovery and registration of handicapped children be made one of their normal functions and that in an unorganized territory this be made a function of the Ontario Department of Health."
- 266. The other recommendations referred to the establishment of specialist clinics to be held, where possible, in community hospitals; the payment for treatment of poliomyelitis be extended to include the hospitalization of patients who require to be admitted, and lastly, but most important, that;-

"In finding an overall program for registration, treatment, education and rehabilitation of handicapped children, there be close liaison between the Ontario Departments of Health and Education and in particular, that the extensive information available in the latter Department be utilized by the Health Department in planning the treatment and rehabilitation of handicapped children."

- 267. As part of this survey, one of the purposes was to determine the extent of registration of handicapped children. It was early found that the situation as present in 1950 has not changed appreciably except that some organized health departments are maintaining registers and that many of the voluntary organizations know of handicapped children which are under their supervision as regards to treatment, rehabilitation, etc. However, in the case of the voluntary organization, their interest is primarily disease or condition centered rather than in the whole broad area of handicapping conditions.
- 268. An attempt was made to find out as much information as possible as to the methods employed in other parts of the Dominion. It was soon apparent from discussions with those who had to do with registers, while these were available in some form in most provinces, very few Provincial authorities had adequate registers designed to treat the whole child in the broadest sense.
- 269. One exception was the Province of British Columbia. In this province a voluntary registry commenced operation in 1952. (ii) The purposes of the registry are listed as being three-fold;-
  - To obtain accurate knowledge of the magnitude of the problem of crippling diseases of children in British Columbia.

- 2. With this knowledge, to aid in the development of facilities and organizations to assist in the rehabilitation of these children.
- 3. To assist physicians in the handling and referral of their cases of crippling diseases of children.
- 270. The registry provides liaison with institutions and agencies for child care throughout the province and disseminates information concerning the facilities available for the care and treatment of handicapped children.
- 271. The Ontario Health Survey Committee used the following definition of a handicapped child: -

"A handicapped child is a person under the age of 21 years who, because of congenital or acquired defect, is or is likely to be limited in normal activity."

272. In British Columbia, the definition of a handicapped child is probably more simple in that a handicapped child is defined as:-

"One under 21 years of age who has a disability severe enough to interfere with the normal living, obtaining an education, and later, earning a livelihood."

While the definition is simpler, it is more inclusive in that it recognizes that handicapping extends across the three broad fields of health, education and welfare.

273. The British Columbia Register (iii) is organized under the jurisdiction of the Health Branch of the Department of Health Services and Hospital Insurance and is administered by the Division of Vital Statistics. The Division is assisted by an Advisory Medical Panel of twenty-five representatives of various medical specialties appointed by the British Columbia Division of the Canadian Medical Association. The Chairman and Deputy Chairman of the Advisory

Medical Panel act as part-time medical consultants in the actual day to day work of the registry. The permanent staff of the registry consists of an administrator from the Division of Vital Statistics and three clerical staff members.

- 274. Registrations are received from many sources in order of receipt as follows:
  - Local Health Services throughout the province and from the metropolitan areas.
  - 2) Indian Health Services.
  - 3) Treatment Centres Hospitals and Clinics.
  - 4) Voluntary Health Agencies.
  - 5) Special Schools.
  - 6) Private Physicians.
  - The Division of Vital Statistics from "Physicians Notice of Birth" Reports.

It is stated that the chief source of registration is from the official health agency.

wheel. After filing it can be classified as active or inactive.

Activity relates as to whether the disability will continue to present difficulties, or where the case has been satisfactorily resolved. They are reviewed at intervals of three, six and twelve months, depending on the type of case. An active case is followed until a medical consultant in the local health services feels that it may be reclassified as inactive.

- 276. Further classification takes place as to what is felt is required. These are indicated on the registration form as:-
  - Statistics only in which case the form is coded and recorded but no further action taken although these can be activated as required on request.
  - Advice from the registry where after coding and recording, referral is made to the medical consultant.
  - 3) Active follow-up. This would apply where in the opinion of the medical consultant it appears that the child is not receiving adequate attention in which case the consultant initiates inquiries from the agency and may offer advice depending on circumstances of the case. These cases are reviewed at regular intervals.
- 277. Coding is done by transfer to I. B. M. punch cards. Where a change of address, further disability, or change of status from active to inactive or vice-versa occurs, the punch cards are altered to keep the information up to date.
- 278. All registrations are treated as being strictly confidential and great care is exercised to protect this status. However, statistical data are available to any person or agency having a legitimate interest in the problem of the handicapped child. In the reports made by the statistical division, which has been used to provide this description, a great deal of statistical information is available.
- 279. For purpose of follow-up, which is so important in these cases, information is provided to the official health service agencies in the province to provide:-

- An alphabetical index of all registered cases within each Health Unit area.
- 2) An alphabetical index of all registered cases in each school district.
- 3) An index of all registered cases within each Health Unit area by disability showing all the disabilities registered on each child. In addition, information is provided to the Indian Health Services Agency within the province.
- 280. Another feature of the report is a listing of where services for handicapped children may be obtained relating to the type of handicap and also where the assistance for any particular handicapping condition is available within the provincial borders.
- 281. The Uses of a Central Registry: These are described in the British

  Columbia report as being:
  - 1) A source of valuable statistics.
  - 2) A central index.
  - A central co-ordinating agency.
- 282. (1) Statistics: At the end of seven years use, 13,595 children had been registered, of which 12,440 were still alive and 1,155 had died. This indicated that about two percent of the population under 21 years had been registered as suffering from either a physical or mental handicap severe enough to fit into the registry definition.
- 283. The statistics obtained from the register have been found useful as an aid in the development of programs and facilities. This was particularly valuable in pointing up the necessity of the provision of educational facilities for the retarded and also the placement of handicapped children. Other handicapping conditions such as speech

and hearing, epilepsy and cerebral palsy, are known with the result that various diagnostic and treatment services have been provided in the province.

- while minimal are sufficient to provide valuable information for planning.

  When this information is known for a province, some comparison can be made with statistics originating in other parts of the world which is useful in decisions relative to missed cases, diagnoses being made too late in life and fundamentally, the planning necessary to provide habilitation or rehabilitation. One of the most interesting features that has recently been developed is the possibility of doing good genetic studies.
- 285. (2) Central Index: When the registry is used as a central index, it is possible to locate a group of children with specific conditions or combinations thereof. This is important if special clinics, surveys or research is being carried out. Examples of this were a survey of deaf and hard of hearing cases over 16 years as well as a dental survey of children with repaired cleft palate and harelip.
- 286. (3) Central Co-ordination: As a central co-ordinating agency, the registry supplies data on individual cases covering the various phases of medical care, education and social problems which might affect future employment since these are collected and gathered into one central place. Further, it provides an opportunity for review.
- 287. One of the best features as it applies to co-ordination is through the accumulation of information so it is possible through representation on

the various Boards, Medical Advisory Committees, and other ways to prevent overlapping and waste of effort.

#### 288. SUMMARY

- Although the establishment of a Register of Handicapped Children was recommended in the Ontario Health Survey 1950, none has been established in this province.
- 2. Other provinces have established registers. The best of those would appear to be that being maintained in the Province of British Columbia. The numbers of personnel involved is not great considering that at the end of 1959, 13,595 children had been registered. In Ontario a very effective Tuberculosis Register has been maintained by the Department of Health and the necessary experience, equipment and personnel with knowledge of registry operation is available.
- 3. It can be anticipated in this province, as is the case in British Columbia, that the most effective notification will be supplied by the official health agency. However, many voluntary groups which are condition orientated; because they receive a considerable amount of money in direct Provincial grants, would be expected to provide information as well.
- 4. It cannot be anticipated that compulsory registration is desirable or effective inasmuch as only 60% of the tuberculosis cases in the province were registered the last year. This is the case, despite the fact that registration is mandatory on the part of the physician. This is not a major problem inasmuch as where children are under active treatment by their attending physicians, the need for registration other than for statistical purposes is not as great.

- These children which represent 50% of those handicapped will become known to the register when they start school.
- 5. The value of this registration has been outlined as a source of valuable statistics, as a central index and as a central coordinating agency. All of these functions are vitally important if the handicapped are to receive the best possible attention.

  This not only applies to diagnosis and treatment but also to rehabilitation.
- 6. The value of a register in rehabilitation of older children is impressive. In British Columbia several studies have been made and many handicapped have been rehabilitated successfully. This resulted in a major saving of public funds.
- 7. The information obtained from a register is of vital importance to those concerned with the study of genetic and hereditary factors contributing to handicapping conditions.
- The establishment of a register as stated in the British Columbia
   Report endeavours, and is successful, in preventing overlapping
   and waste of effort.
- 9. The Registry strives to keep aware of all agencies which are involved with children who might be handicapped. This information would be valuable to the many persons involved who require this information to ensure that the handicapped get the best possible diagnosis, treatment and rehabilitation.

## 289. RECOMMENDATIONS

- It is recommended that the Provincial Department of Health be
  approached and they be requested to establish a voluntary registry
  in this province similar to that presently in operation in British
  Columbia. Modifications based on geographical or other
  considerations could be made. However, the fundamental
  principles should be adhered to.
- 2) It is recognized that only the Provincial Department of Health could effectively operate such a Register. The additional cost of which would not be great as many of the facilities are now in existence in various divisions of the Department. Furthermore, the Provincial Department is the only place where the Register can be most effectively established and continued in comparison to voluntary associations or other interested bodies.
- 3) References are made to the very excellent reports that have been prepared by the Division of Vital Statistics relating to the Register for handicapped children in the Province of British Columbia.

#### References

i) Report of the Ontario Survey Committee - Vol. III, pp 420-421, Oct. 1, 1952.

Dept. of Health Services & Hospital Insurance - Health Branch -Division of Vital Statistics - Special Report #37 - August 1959.

iii) · Ibid - Special Report #53 - January 1961.

#### 290. SECTION EIGHT: VOLUNTARY AGENCIES

As an appendix to this section, the questionnaire used in the survey of official and voluntary agencies should be studied. The information relative to twenty-three voluntary agencies has been collected and the results previously distributed to those attending the Second Conference.

- 291. All of the voluntary agencies who were known were asked to participate in the survey and most of them willingly agreed to do so. It is unfortunate that one or two large agencies did not. Where possible, information regarding their activities has been obtained from various reports and this is in our files.
- 292. A study of the questionnaire will show that the sub-committee of the

  Child Welfare Committee is interested in what a great many other

  persons, including the official agencies at all levels, are interested.

  In the United States, the Rockefeller Foundation provided financial

  support for a two-year survey of voluntary agencies. The preliminary

  results of this survey would indicate that in many instances the

  activity of the voluntary agency leaves much to be desired.
- voluntary agency because in many cases it would appear that the profession themselves stimulated parent groups and others to form an agency. It is readily apparent that this advice was given in good faith for the purpose of providing a milieu in which persons with the same problem could meet together and by doing so furnish that inter-personnel support so necessary to those encountering these problems of handicapping conditions occurring within their families or among those in whom they had a particular interest.

- 294. Unfortunately in many instances this interest often was transcended by the development of vested interest. This resulted in organizations being set up with executive officers who may have had in the first instance an interest in a condition causing a disability or handicap but subsequently this interest became submerged by a desire to perpetuate their existence.
- 295. The public for their part, concerned with their own affairs, were called upon and this is still happening, to provide large amounts of money to ostensibly do something for the handicapped child with resulting fragmentation of effort, overlapping, dissipation of funds, unorganized research and those other evils having little to do with the original purpose. Those in the public who thought about the situation could only realize the shortcomings of many of these programs despite their inherent desire to do something for those less fortunate.
- History of Voluntary Organization Development: The answers provided by responsible persons in the voluntary organizations reveal that these developed about the turn of the century. Progress was slow until after the first world war when a few additional ones had their organization. Following the second conflict the expansion was explosive. This last happening can be attributed in part to the successful results of medical treatment, the introduction of antibiotics and in particular, the development of anti-polio vaccine. Parents of children with handicaps became carried away with the successful production of a vaccine to eliminate a major cause of physical handicapping with the natural hope that if medical science could accomplish this, there seemed a good possibility that the same could happen for many other crippling or handicapping conditions.

- 297. What Constitutes an Effective Voluntary Organization: The statement that "nothing succeeds like success" is particularly applicable in discussing voluntary organizations. This has been well demonstrated in this province through the activities of those voluntary organizations concerned with the problem of tuberculosis. In 1900, tuberculosis was the first cause of death. At the present time it ranks twelfth or thirteenth. During this period of sixty years, much has happened not only in the nature of the disease itself but in its control. The medical profession has been particularly active and their contributions have been very impressive. Sir William Osler was the guiding genius in focusing attention on the disease and what could be done to bring professional and lay efforts to bear on the problem.
- 298. The Canadian Association for the Prevention of Consumption, now the Canadian Tuberculosis Association, was founded in 1900. The first Canadian sanatorium had been opened by the National Sanatariam Association at Muskoka in 1897. The combined efforts of the public and the profession since that time have been notable and these should provide a blueprint for the activities of any voluntary agency.
- All too often too much attention is focused on the nature of the disease with too little regard for the principles involved in forming a plan of action. The medical profession in their normal activities must be flexible as in their day to day activities they deal with many different persons. They, therefore, are in the most favourable position to advise interested lay persons on their activities. While as specialists in many instances, their interest is single disease centered, by training they can possibly best appreciate the necessity

for a varied plan of attack on the many handicapping conditions affecting the human race.

- 300. <u>Basic Principles Necessary for Successful Action:</u> In analyzing the principles that have been followed in the attack on the problem of tuberculosis, certain features may be discerned:
- 301. 1) <u>Disease or Condition Interest</u> The Canadian Tuberculosis

  Association at first restricted their activity to one disease. However,
  this was not a narrow interest but rather extended to the effects of the
  disease on the individual, his family, and the community at large.
- 302. 2) <u>Incidence and Registration</u> It was recognized that if any effective action was to result, the cases must be known, and must be registered so that follow-up was possible.
- 303. 3) Referral It was understood that some method must be developed to direct these sufferers to primary sources of treatment and thereafter refer them back to the official or voluntary agency in the community.
- 304. 4) Facilities for Diagnosis and Treatment Facilities for treatment were considered absolutely essential and it has been previously stated that the first sanatorium was established some three years before the Society was organized. With the limited knowledge at the time concerning the disease but using what was known, the sanatorium was located in a remote part of the province. This undoubtedly was stimulated by the statement of Thomas Sydenham some two hundred years earlier that fresh air and horseback riding was valuable in the treatment of tuberculosis. However, various medical men in the province had established segregated treatment for tuberculosis patients in tents and other structures away from what hospitals existed in the province at that time.

- 305. It was not many years later that the base for treatment was broadened to include surgical and other procedures and the activities of the paramedical groups. However, it is interesting to note that these personnel when they became available were employed by sanatoria.
- 306. The same can be said for the provision of educational and vocational services and the necessity for social service participation.

  The principle of decentralization of facilities was recognized. While the Muskoka Hospital was the first, within forty years sanatoria had been established on a regional basis to serve the whole of the province.

  This is a fundamental concept that must be adhered to in the planning of diagnostic and treatment facilities in the fullest sense for all handicapping conditions.
- 5) Financial Responsibility Although the Muskoka Hospital in its
  earliest days was called the "Muskoka Free Hospital, experience
  quickly dictated that the problem of tuberculosis was one for society
  as a whole, therefore, in 1929, Saskatchewan provided "free" treatment.

  This, of course, was a misnomer in that the residents of the province
  were paying bills through their taxes, but fundamentally the principle
  was recognized that payment for treatment by the total population
  was necessary if the plan of attack on the disease was to be successful.

  Subsequently, all provinces adopted the principle and this later was
  improved by reciprocal financial arrangements between the various
  Provincial authorities.
- 308. It was recognized as well that for successful rehabilitation, allowances were necessary for the wives and families as well as post-sanatorium financial support for the patient himself.

- 309. 6) Lay and Professional Education In due course the Society recognized that this was most important to dispel ignorance regarding the disease on the part of the public and to, in every way, improve professional knowledge so that diagnosis and treatment would be more effective.
- 310. 7) Research Once facilities for diagnosis and treatment were provided, it was possible to conduct research activities. This was not centralized in one area. It is significant that many valuable findings resulted from the efforts of the staffs of the various sanatoria. With the establishment of a division of the Provincial Department of Health for tuberculosis control, it was possible then to co-ordinate and correlate these research activities so that the benefits could accrue to all sufferers.
- 311. It was recognized that adequate diagnosis and treatment would only follow when personnel were available in sufficient numbers and possessing adequate qualifications to provide the best treatment possible. The professional and lay employees of the sanatoria maintained close relationship with all those others in the communities they served. In general, the medical staff of the sanatoria acted as consultants to the practising profession and held hospital appointments as such. The result of this close relationship naturally provided a great deal of strength to the overall medical facilities and by good liaison the resulting professional co-operation did much to produce a united effort.
- 312. 8) Advisory Committees It is significant that the conduct of sanatoria operations is invariably under the direction of strong lay groups made up of influential citizens in the community.

- 313. The directors of the Ontario Division are equally divided between professional and lay persons. All of these take a particular interest in the appointment and bring to bear on the various problems encountered the lay and professional opinions so necessary to resolve any difficulties that may develop. This should be a fundamental principle in the direction of any voluntary association.
- 314. 9) Fund Raising The funds for the support in part of some sanatoria activities are provided by the sale of Christmas Seals. A portion of the monies raised is contributed to the provincial voluntary agency.

  In 1904 Holboell introduced the Christmas Seal in Denmark and in 1927 this was adopted on a national basis in Canada.
- The significant feature of this form of money raising is first the 315. amount of money raised which exceeds that of other individual voluntary agencies and public participation. Funds are raised through the activities of local or community Seal Sale Committees. Publicity is of the low pressure, dignified type. Of the monies raised, by far the greatest portion is spent in the local community. It is interesting that the affairs of the Ontario Association are carried on for about one cent per capita of the population of the province. If this large amount of money can be raised so effectively, it follows that certain fundamental principles are adhered to. These would relate to the necessity of obtaining the help and support of many well motivated persons at the community level. Undoubtedly this is only possible when these hard-working individuals are aware that the program is effective in their own communities and liaison with the official agency represented by the sanatoria and their staff is good. In all instances, professional relationships are excellent as well.

- This applies not only to the practising profession but also to the official health agency operative in the community.
- be done by someone else when these official agency activities are set up and organized. The relationship between sanatoria staffs and health departments are universally excellent in this province. During the course of the survey it was found that the anti-tuberculosis programs were well developed all across the province and it was also discovered that relationships between those engaged in treatment, the official health agency, the profession and the public, were universally excellent.
- 317. The amount of money raised by the voluntary groups, as stated, is very impressive considering that the programs developed at Christmas time to do this are not blatant but well organized, impressive and dignified.
- 318. The public is also aware that only a small amount of money raised, namely, one cent per capita, in this province is devoted to the activities of the Provincial Voluntary Organization.
- 319. 10) Evolution The Ontario Division of the Canadian Tuberculosis Association was formed in 1945 so that its history is comparatively recent. Previous to that time the Canadian Tuberculosis Association was the voluntary agency for the province.
- 320. Reading the story of progress in tuberculosis control demonstrates the gradual evolution of an effective attack on a major disease problem. It is significant that a sanatorium was built before the voluntary agency was developed on a national basis, however, a local branch, namely, the National Sanatorium Association, was operative in the City of Toronto three years before.

- 321. Within nine years, the first diagnostic clinic was established. It was thus recognized that institutions can only properly function when diagnostic services are available. In 1927, the first Christmas Seal sale took place. This was in recognition of the fact that the public wished to make their contribution and this was best done on an organized basis. Four years later the first legislative action took place when legal isolation of recalcitrant patients was provided for. Ten years later the first mass survey was organized again demonstrating the necessity for more complete diagnostic services.
- 322. Antibiotic therapy was started within three years and this was followed two years later by the use of anti-tuberculous drugs.
- 323. In 1955, the first medical section of the Canadian Tuberculosis

  Association was formed. This was in recognition that the treatment
  of any disabling disease depends on close co-operation between the
  voluntary agency and the professional groups concerned.
- 324. With a reduction in the number of patients needing long term treatment in sanatoria, empty beds followed. These beds were quickly utilized for the treatment of other conditions relating to diseases of the chest.

  Another more recent development has been the conversion of sanatoria beds to other uses. Examples of conversion of available beds for other uses are the Children's Psychiatric Research Centre at London, the Royal Ottawa Sanatorium, the Mountain Sanatorium, Hamilton, and others to a lesser degree.

#### 325. SUMMARY

A rather complete description of one voluntary agency has been given, namely, the Canadian Tuberculosis Association and its Provincial counterpart. This has been done since the Association is one of the

oldest on the national scene. What is more important is the value of a voluntary agency has been well demonstrated.

- 326. The activities of this agency have been well received by the public through their financial support through Christmas Seal purchases, donations and legacies (i). Their activities have been such as to provide a blueprint for all voluntary agencies.
- 327. The success of this is demonstrated by the reduction of death and disability although the problem of tuberculosis still remains in different forms and with different problems.
- 328. With a reduction in the length of acute treatment, the Association has through its community branches diverted some of its resources to other health problems. In doing so, however, it has recognized that the effective treatment of disabling conditions must be an integrated effort between many persons and groups.
- 329. The most important feature of these activities has been a recognition of the fact that certain things can be done best by individual persons or agencies. Therefore, the Association has been active in developing facilities at the regional or community level. With the completion of these they have taken their proper place in complementing the efforts of the official agency and the professional persons involved in the treatment and prevention of disease, and health promotion in general.
- 330. At all times they have recognized that the combined efforts of many professional and lay persons are necessary if any disabling problem is to be resolved.

#### 331. RECOMMENDATIONS

- 1) Voluntary associations that are disease or condition orientated can serve a very useful purpose. The organization of these should be encouraged when the problem is of such magnitude as to warrant this development and where the disabling condition is not being adequately cared for.
- 2) The principle of one agency being responsible for several conditions is not recommended in that there is a resulting loss of public support as has been demonstrated in other provinces.
- 3) Voluntary agency programs should follow the pattern that has been evolved effectively in the case of the Canadian Tüberculosis Association and its provincial counterpart.
- 4) Essentially the voluntary agency should only complement the activities of the professional bodies and official agencies. If voluntary agencies have provided staff to carry out medical or para-medical tasks in a community these should be withdrawn when professional persons and treatment facilities are available locally. The same principle applies when official agencies are established and staffed.
- 5) The voluntary agency should be active in promoting public education to stimulate the provision of facilities necessary to adequately deal with any handicapping situation.
- 6) Branches at the community level have demonstrated that large amounts of money can be raised. Monies raised must be expended at the local level to provide complementary facilities and activities to the professional bodies and the official agency. The necessary public education will then become one of their major functions.

- 7) It is recognized that a certain amount of money raised must be given in support of the central organization. However, it is significant that in the case of the Ontario Tuberculosis Association the budget represents one cent per capita for the total population of the province, or one twentieth of the total funds raised.
- 8) It is recognized that legislation is necessary to enforce treatment of neglected children suffering from handicapping conditions.

  The numbers of parents who are recalcitrant are not large. It is considered that the provisions of the Child Protection Act, if enforced, are adequate to bring about the required treatment.

Reference (i):

(Canadian Tuberculosis Association, Christmas Seal News, Bulletin #7)

# 332. PROPOSED SURVEY OF PRIVATE AND PUBLIC AGENCIES PROVIDING SERVICES TO HANDICAPPED CHILDREN IN ONTARIO (Appendix)

- The type of handicapping condition or conditions for which services are provided.
- Has the agency information on the incidence of the handicapping condition or conditions and the percentage of these that require services.
- 3. Case load.
- 4. Geographic distribution.
- 5. Age groups served by the Agency.
- 6. Sources and methods of referral to the Agency.
- 7. Eligibility for services.
- 8. Does the Agency maintain a register?
- 9. Range of services provided:

- 9. a) Physical and Mental Health Services
  - (i) Diagnostic
  - (ii) Surgical, medical and dental services, consultation and/or treatment
  - (iii) Physio, occupational and speech therapy
  - (iv) Prosthesis and appliances
  - (v) Psychiatric, psychological and social services for the management of the child's social and emotional adjustment, and assisting the family in planning the care of the child.
  - b) Special educational services
  - c) Social and vocational services for older children counselling, training, job placement and follow-up training.
  - d) Financial responsibility assumed by the Agency in providing services appliances, diagnosis, treatment, etc.
  - e) Cost of services per patient and schedule of fees.
  - f) Transportation services.
  - g) Use of services by other agencies in the rehabilitation program.
  - h) Provision for multiple handicaps.
- 10. a) Percentage of patients requiring institutional care. Is this institutional care required now or in the future?
  - b) Percentage of cases requiring periodic supervision.
- The means used by the agency to inform lay and professional groups as to their interests and/or services in the handicapped field.
- 12. Research projects and how financed.
- Number of employees and qualifications and number of voluntary workers.
- 14. Personnel of Advisory Committees.
- 15. Facilities and services available in and out of the physical plant, including those available for outlying areas.
- 16. Plans for future development.
- 17. Budget and source of revenue.
- 18. What does the agency consider to be the unmet needs in Ontario for the handicapping condition or conditions with which it is primarily concerned.

333. SECTION NINE: A PROPOSED CO-ORDINATING COUNCIL

Among the over ninety recommendations of the Second Conference,

was one originating from each of the three workships of Health,

Education and Welfare.

334. The Sub-Committee of the Child Welfare Committee, on the advice of the Advisory Committee, gave the highest priority to the following recommendation:

"That a Co-ordinating Council be established under the auspices of the Ontario Medical Association with representation from the three broad areas of responsibility, namely - Health, Education, and Welfare, for the purpose of co-ordinating agencies and integrating services."

- 335. In the discussion relating to the proposals, the delegates attending the Conference proposed that although this Co-ordinating Council should be "initiated" by the Association, it should not be held responsible for sustaining such a body, particularly, financially.
- 336. The delegates also were very careful to emphasize that this should not be another association in the voluntary agency field. The opinion was that there were enough of these at the present, but rather that it should be a co-ordinating body without vested interest.
- 337. These recommendations are reasonable and sound and should be followed. The problem is how this best can be done to meet the specifications put forward by the delegates who undoubtedly paid a great deal of attention to the mechanics and functioning of such a council and what is more important, recognized the need.

- of how best to develop a framework conforming to the criteria

  proposed by the delegates and approved by the Advisory Committee. It

  is significant that no such council exists at the moment although in

  some areas Social Welfare Councils have been developed.
- 339. Throughout the survey it was repeatedly impressed upon me that the Ontario Medical Association was to be congratulated on initiating the program and further it was the considered opinion of most of those interviewed that the Association was in the best position to bring about an effective Co-ordinating Council.
- 340. Since it was emphasized that another organization should not be formed, it follows that the Ontario Medical Association must delegate this task of formation to a committee. It seems logical, therefore, that the best committee to do this would be the Child Welfare

  Committee or a sub-committee similar to the one that has been concerned with the problem of the handicapped. Criteria could be:-
- not members to strengthen the workings of the various
  committees. Therefore, there would appear to be no difficulties
  in enlarging the sub-committee of the Child Welfare Committee
  to include representatives from the two other important fields,
  namely, education and welfare. If it was deemed important and
  necessary, the two other groups or official agencies that should
  be represented would be the Provincial Departments of Labour
  and Reform Institutions.

- Advisory Committee in their earliest deliberations selected an Advisory Committee representative of those professional persons who are concerned with the handicapped in the three areas of health, education and welfare. This Advisory Committee performed a most useful task in our deliberations and it is considered essential that a similar advisory committee should be chosen to assist the nucleus of representatives described above.

  Members of this advisory committee should be chosen to give complete geographic representation for the whole of the province.

  This was partially achieved in selecting the members of the Advisory Committee that has functioned so well up to date.
- 343. 3) To effectively deal with a large portion of the handicapped, it is important that the official agency represented by the provincial departments should be a part of the proposed co-ordinating council.

  The departments involved are primarily those of health, education and welfare but again, the Departments of Labour and Reform Institutions should be considered.
- The reasons for the three main governmental departments can be readily understood but it is also important to recognize that employment opportunity for the handicapped is most essential.

  This can be facilitated by having the Department of Labour represented. Through this department it will be possible to have contact with the National Employment Services.
- 345. Including the Department of Reform Institutions has been recommended by the Advisory Committee since a large number of those in custody have psychiatric problems. It was the

considered opinion that possibly many of these persons could be salvaged. Certainly they must be classified as handicapped persons.

- 346. 4) The final group that must be considered are those representing the voluntary agencies and the professional groups. The need for this can be understood because that is the fundamental purpose of the Council, namely, to provide integration and co-ordination both of programs and service.
- 347. Administrative Recommendations It must be recognized that the central or nucleus committee from the Child Welfare Committee along with representatives from health and welfare and possibly those from the Departments of Labour and Reform Institutions would be the executive body for the Council.
- 348. An advisory committee would be essential since this group is representative of those who are not most intimately and fundamentally concerned with the overall problem of handicapping whether it refers to health, education or welfare.
- 349. Representatives from the Departments of Government would fulfil two main duties, namely, to advise on what services are available and in turn would supply the means of communicating to government what needs had been exhibited by the Advisory Committee or others.
- 350. Representatives from the Voluntary Agencies would in turn be in a position to outline their programs and again, of equal importance, would be in the position to report back to their own organizations the opinions of others making up the Council.

- 351. Finally, the professional groups on their part, would be able to provide similar information, thus giving a two-way communication from their organizations to those others involved and vice-versa.
- International affiliation. At the National level, this should be with the Canadian Council for Crippled Children and Adults and thus through this organization to the International Society for Rehabilitation of Disabled. It is appreciated that the title of these organizations tends to be restrictive, however, it has been recognized by both of them that the attack on the problem of handicapping must have a broad base.
- 353. From reports (i) it would appear that the Australian Advisory Council for the Physically Handicapped has in that Commonwealth a functioning organization. Despite the limitations imposed by the title, it is obvious from reading reports originating from their deliberations that the purposes and activities of the Council are much broader in concept.
- 354. The Honourary Secretary, Mr. Hugh Bedwin, has outlined (ii) the function of the Australian Council as follows:-
  - "a) A centre of information on all facilities available to handicapped people in Australia.
    - A centre of information on all known problems concerning handicapped people.
    - c) A centre of information on all activities and services provided throughout the world dealing with the problems of handicapped people.

- d) A promotion centre where information is directed to stimulate activity in the creation of new facilities.
- e) The encouragement of and implementation of research into these problems throughout Australia.
- f) An advisory bureau, able to provide expert opinions for the setting up of medical, educational and vocational facilities.
- g) An advisory panel which can assess evidence and prepare cases for the implementation of new or amending of standing legislation which might be necessary for the establishment of facilities for handicapped people.
- 355. If these suggestions are acceptable, we would like to be able to be active in the improvement of both child and adult education, technical education, problem-conditions that appear to be common in the field of prostheses, caliper, braces, splints and orthopaedic boots, the expansion and improvement of medical rehabilitation and the development of all aspects of vocational rehabilitation, housing and transport problems of the handicapped, and a public education program."
- 356. The stated functions of this Council are comprehensive but in addition, it is suggested that additional ones could be adopted as follows:
  - 1. The scrutiny of budgets of voluntary agencies.
  - Approval of programs and the use of monies raised, such approval could be made known to the public at large which is called upon to furnish the finances for the operations of voluntary agencies.

- 3. Advice on research needed and where the personnel and finances could be obtained. It is not suggested that this would be restricted to the Council, but rather reference should be made to the Medical Advisory Committee on the National Research Council.
- 4. Assessment of programs both of official and voluntary agencies.
- 5. Public education.
- Any other function that is considered necessary to meet the needs of the handicapped.
- Finances As specifically stated by the delegates, "the Ontario Medical Association should not be held responsible for sustaining such a body, particularly, financially." It is, therefore, obvious that in the early days of the Council it might be necessary to approach various Foundations to provide supporting funds. However, it is considered essential that voluntary agencies and professional groups having membership in the Council would, through membership fees, supply some of the needed finances.
- Departments involved, might be approached to provide certain funds if in turn the Council was prepared to advise Government on the value and need of programs provided by the voluntary agencies in particular. A perusal of the public accounts of the province show that many of these organizations are given provincial grants from different departments of government. It is appreciated that eventually the Council should be self-supporting financially through these sources of revenue.

- 359. Council Development The delegates realized that the Association should not be responsible financially for sustaining the organization and it could further be proposed that the participation of the Sub-Committee should not extend beyond a stated period of time.

  Thereafter, representation from the Ontario Medical Association would be provided by members of the Association who were functioning on the Advisory Committee or through the professional groups.
- 360. It is recognized as well that much new ground might be broken in the establishment of such a Council as there is very little experience available to guide those concerned. However, this is not considered to be a handicap in itself, as a fresh approach to the various difficulties associated with the integration of services would be welcomed.

#### 361. SUMMARY

- The delegates at the Second Conference recommended that a Co-ordinating Council be established under the auspices of the Ontario Medical Association with representation from the three broad areas of responsibility, namely, health, education and welfare, for the purpose of co-ordinating agencies and programs and integrating services.
- 362. 2) Suggestions have been made as to how this might be set up as a function of a Sub-Committee of the Child Welfare Committee of the Association.
- 363. 3) Representation has been outlined for those concerned either

representing the official or voluntary agencies and professional groups.

- 364. 4) An Advisory Committee is considered as essential and the composition of this has been suggested.
- 365. 5) It is recognized that the executive powers of the Council should be delegated to an executive body composed of three representatives from the Child Welfare Committee and one each from Education and Welfare. Subsequently, this executive group might be enlarged by the inclusion of representatives from the Departments of Labour and Reform Institutions.
- 366. 6) It is recognized that finances in the earliest stages would possibly have to be sought from foundations or other interested persons but it is necessary as well that those associations seeking membership in the Council should eventually be responsible for the complete financing.
- 367. 7) The Ontario Medical Association through its committee and sub-committee should only be responsible for the initiation which should not extend beyond a five year period.
- 368. 8) The duties of the Council have been outlined in part.

  These have been based on those of the Australian Advisory

  Council for the physically handicapped and others that
  have been suggested.

#### 369. RECOMMENDATIONS

It is recommended that the Ontario Medical Association give serious consideration to the establishment of a co-ordinating council as requested by the delegates attending the second conference on Handicapped Children. This recommendation subsequently was assigned the highest priority of the more than ninety recommendations made by the Advisory Committee for the program.

#### References:

- Sir Kenneth Coles et al Proceedings of the 8th World Congress of the International Society for the Welfare of Cripples. PP 310 et. seq.
- Hugh Bedwin Honorary Secretary Australian Advisory Council for the Physically Handicapped - Newsletter 25th September, 1961.

# ONTARIO MEDICAL ASSOCIATION COMMITTEE ON THE MEDICAL ASPECTS OF TRAFFIC ACCIDENTS

#### RECOMMENDATIONS

#### 1. Research

The Ontario Medical Association strongly urges an active and comprehensive program of research into the medical aspects of traffic accidents.

#### 2. Driver Fitness

The Ontario Medical Association welcomes the growing liaison between the provincial licensing authority and the medical profession. Close collaboration in dealing with the issue of driving licences to impaired individuals should result in the compilation of a useful guide for the licensing authority and individual physicians.

#### 3. Safety Devices

The Ontario Medical Association supports the national campaign of the Canadian Highway Safety Council in promoting the use of seat belts and urges government support by installing seat belts in all government-owned vehicles.

#### 4. Driver Education

The Ontario Medical Association commends the driver education programs of high school students as an extracurricular activity and urges active government support in this work.

#### 5. Alcohol and Road Traffic

The Ontario Medical Association particularly urges the passing of new legislation dealing with the drinking driver. In common with the British Medical Association and the World Health Organization, we recommend that breath

tests to determine blood alcohol levels be made mandatory. We also recommend that arbitrary blood alcohol levels be established by law, over which it is unlawful to drive a vehicle on a public highway. A blood alcohol level of 0.05% is suggested. This blood level is reached, for an individual weighing around 150 pounds, after drinking 4 1/2 oz. of hard liquor within an hour.

Canada lags far behind many western countries in this type of legislation. The O. M. A.'s intention is not punitive but rather to seek an extension of quarantine laws which would legislate "alcohol carriers" off our highways by suspension or cancellation of permits to drive.

# 6. Ambulance Services

The Ontario Medical Association, after two extensive surveys, makes the following recommendations:

- That provision be made for proper compensation of ambulance operators for traffic emergency services.
- b) That legislation at the provincial level be enacted to govern the licensing, staffing and equipping and general operations of ambulances.
- c) That such legislation recognize that ambulance services are dual in nature, and provide not only transportation for the injured but also first aid. As para-medical services, ambulances should operate under medical supervision.
- d) That regulations must be evolved to guarantee the adequate training and certification of ambulance attendants with due emphasis upon periodic refresher courses and re-certification to ensure continuing familiarity with, and competence in, accepted techniques.
- e) That provision be made for the co-ordination of communications' services throughout the province in order that the facilities of police, ambulance services, hospitals and physicians, may be utilized to the maximum advantage of all concerned, particularly the accident victim.

# 7. References

- Report of Department of Transport of Ontario for the first 8 months of 1961.
- Report of a sub-committee of the B.M.A. on Relations of Alcohol to Road accidents.
- 3) Report of Expert Committee on Alcohol, World Health Organization.
- List of countries with summary of legislation on alcohol and driving.
- 5) "Drinking and Driving", H. Ward Smith, Ph.D., Director Attorney-General's Laboratory, Toronto.
- 6) "Breath Tests for Alcohol", H. Ward Smith, Ph.D. and D.M. Lucas, M.Sc.
- "Ambulance Services and Traffic Casualties", report of the Cornwall Area Traffic Casualty Study, Dec. 1, 1959 -Nov. 30, 1960, L.A. Caldwell, M.D., Cornwall.

#### 8. Reference #1

Ontario Department of Transport

The Physical Condition of Drivers in Motor Vehicle Accidents January 1 to August 31, 1961

In the period of January 1 to August 31, 1961, there were 90,699 drivers in all accidents of a reportable nature to the Ontario Department of Transport. A review has been conducted of the 53,444 motor vehicle accident reports in which these drivers participated to show the condition of the driver. The classification "Ability impaired" also included drivers who were shown to be intoxicated.

#### 9. URBAN

Condition of Driver	In all accidents	Fatal	Personal Injury	Property Damage Only
Apparently normal	54,781	170	15,598	39,013
Ability impaired	1,458	7	457	. 994
Had been drinking	2,619	29	950	1,640
Extreme fatigue	122	-	65	57
Physical defect	194	5	74	115
Not stated	1,187	18	398	771
Total drivers	60,361	229	17,542	45,590

10. RURAL

Condition of Driver	In all accidents	<u>Fatal</u>	Personal Injury	Property <u>Damage Only</u>
Apparently normal	26,482	464	6,134	19,884
Ability impaired	560	16	151	393
Had been drinking	2,561	108	871	1,582
Extreme fatigue	296	8	95	193
Physical defect	120	5	38	77
Not stated	319	64	69	186
Total drivers	30,338	665	7,358	22,315
Total urban & rural	90,699	894	24,900	64,905

- 11. Urban locations consist of 243 cities, towns and villages with a population of 1,000 and over.
- 12. The combined urban and rural figures show that 81,263 or 89.6

  per cent drivers as "normal";

  2,018 or 2.2 per cent "ability impaired";

  5,180 or 5.7 per cent "had been drinking";

  418 or .5 per cent "extreme fatigue";
  - 314 or .3 per cent "physical defect";
  - 1,506 or 1.7 per cent "not stated".

#### 13. The Drinking Drivers In Fatal Accidents

Particular attention has been focused on the drinking driver and especially when involved in a fatal accident. Studies conducted in the U.S.A. on this subject have indicated that up to 50 per cent of fatal accidents have involved drinking drivers. Based on this study for Ontario, out of a total of 640 fatal accidents a drinking driver was reported in 160 or 25.1 per cent of the total fatal accidents. Our report is factual and the data derived from actual police reports. Of the 160 drivers who had been drinking and in fatal accidents, 80 were killed; in addition another 96 also met death due to these accidents. The ninety-six killed were made up of the following classifications:

6 other drivers, 63 passengers (with the drinking driver and in other vehicles), 23 pedestrians, two bicyclists, one motorcyclist and one miscellaneous or a total of 176. This 176 represents 23.2 per cent of the total killed in traffic of 758 for the eight-month period.

- 14. There were six female drivers or 3.7 per cent of this total who "had been drinking" out of the total of 160; four were killed and in one instance a passenger also killed; a passenger with each of the other two female drivers was killed.
- The causes of these accidents showed that "speed" was the factor in 31.0 per cent, "lost control" in 26.3 per cent, "inattentive driving" in 19.4 per cent; other incorrect driver actions accounted for the remaining 23.3 per cent, i.e., on wrong side of road, did not have right-of-way, etc. A breakdown of the 160 drivers by age group is shown hereunder, the youngest driver involved as 17 (2) and the oldest 78 years, who had been drinking and driving.

Age Group	Number	_%
16-19 years	12	7.5
20-24 years	44	27.5
25-34 years	53	33.1
35-44 years	27	16.9
45-54 years	15	9.4
55-64 years	7	4.4
65 and over	2	1.2
Total	160	100.0

#### 16. Extreme Fatigue

The 418 drivers shown in this classification stated they had either been driving too long or had commenced their driving without being properly rested. A study of the age groups related to this condition is interesting.

#### 17. Physical Defects

In "all accidents" there were 314 drivers or .3 per cent in

this category. The leading physical defect as stated by the driver to the investigating police officer is "I blacked out" or had a dizzy spell. These two are followed by amputees, drivers with defective vision and hearing, epileptic seizures, diabetic reactions, strokes and heart attacks, etc. Of the 314 drivers there were 30 amputees or 9.6 per cent of the total.

#### 18. Summary

25 - 34 years

A further report for the full year 1961 will be carried out.

However, it is not anticipated that there will be any radical changes in the percentages of the various classifications.

19. <u>Condition of Drivers Related to Age Group</u>

Age group	Total drivers i accidents	n	Apparently normal	%	Ability	
Under 16 (illegal	) 124	.1	110	88.7		
16 - 19 years	9,397	10.4	8,835	94.0	58	.6
20 - 24 years	15,490	17.1	13,749	88.8	247	1.6
25 - 34 years	25,222	27.8	22,306	88.4	614	2.4
35 - 44 years	18,855	20.8	16,766	88.9	579	3.1
45 - 54 years	11,982	13.2	10,833	90.4	310	2.6
55 - 64 years	6,240	6.9	5,736	91.9	154	2.5
65 and over	2,669	2.9	2,471	92.6	39	1.5
Not stated	720	.8	457	63.5	17	2.4
	Had been	Extrem	e Ph	ysical	No	ot
Age group	drinking %	fatigue	<u>%</u> de	fect	% stat	ed _ %_
Under 16 (illegal	) 1 .8				1	13 10.5
16 - 19 years	262 2.8	73	. 8	26	.3 14	1.5
20 - 24 years	1,084 7.0	130	.8	29	.2 25	1.6

126

1,783

359

1.4

Age group	Had been drinking	_%_	Extreme fatigue	%	Physical defect	%_	Not stated	_%
35 - 44 years	1,163	6.2	45	. 2	50	. 3	252	1.3
45 - 54 years	601	5.1	29	. 2	48	. 4	161	1.3
55 - 64 years	195	3. 1	10	.1	61	1.0	84	1.4
65 and over	60	2. 2	4	. 2	65	2.4	30	1.1
Not stated	31	4.3	1	. 1	1	.1	213	29.6

## Totals -

Drivers in accidents 90,699 Apparently normal 81,263 Ability impaired 2,018 Had been drinking 5,180 Extreme fatigue 418 Physical defect 314 Not stated 1,506

# 20. The estimated number of drivers by age group as of the 31st

# August, 1961 are as follows:

16 - 19 years	166,806 or 7.1%
20 - 24 years	288,974 or 12.3%
25 - 34 years	667,225 or 28.4%
35 - 44 years	556,805 or 23.7%
45 - 54 years	368,853 or 15.7%
55 - 64 years	199,698 or 8.5%
65 and over	101,024 or 4.3%
Male drivers	1,759,642 or 74.9%
Female drivers	589,743 or 25.1%

# 21. Percentage of drivers by age group shown as "ability impaired"

# or "had been drinking" et al.

	16-19	20-24	25-34	35-44	45-54
Ability impaired	2.9%	12.2%	30.4%	28.7%	15.4%
Had been drinking	5.1%	20.9%	34.4%	22.4%	11.6%
Extreme fatigue	17.5%	31.1%	30.1%	10.8%	6.9%
Physical defect	8.3%	9.2%	10.8%	15.9%	15.4%

	55-64	65 & over	Not stated	Total	Of
Ability impaired	7.6%	1.9%	. 9%	100.0%	2,018
Had been drinking	3.8%	1.2%	. 6%	100.0%	5,180
Extreme fatigue	2.4%	1.0%	.2%	100.0%	418
Physical defect	19.4%	20.7%	.3%	100.0%	314

Vehicle Accident Statistics Division Ontario Department of Transport October 12, 1961

#### 22. Reference #2

Relation of Alcohol to Road Accidents
Report of Special Committee of the British Medical Association.
London, 1960 - V111 - Conclusions:

- The committee is satisfied that the official returns for accidents caused by drivers who have taken alcohol underestimate very considerably the number of accidents due to this cause.
- 2) In a high proportion of accidents in which pedestrians have received fatal injuries it has been found that the victim has taken alcohol.
- 3) Relatively low concentrations of alcohol in the tissues cause a deterioration in driving performance and increase appreciably the likelihood of accident.
- 4) The existing legislation does not come into effective operation until a very much higher concentration of alcohol in the tissues has been reached, and is unsuccessful as a measure to prevent accidents caused by alcohol.
- 5) Clinical examination in the absence of biochemical tests is neither sufficiently sensitive nor reliable enough to detect deterioration in driving performance of this degree.
- 6) A clinical examination is an essential part of the examination

- of persons suspected of driving vehicles under the influence of alcohol, since it is the only way of detecting physical illness and the presence and extent of any injury.
- 7) The committee believes that a substantial reduction in the number of accidents caused by alcohol has been achieved where it has been made an offence to drive a motor vehicle when the concentration of alcohol in the tissues is in excess of a certain level.
- 8) In addition to the conventional methods of taking samples of blood or urine an apparatus is now available for taking samples of breath from which the concentration of alcohol in the tissues can be rapidly and accurately estimated.
- 3) The committee considers that a concentration of 50 mg. of alcohol'in 100 ml. of blood while driving a motor vehicle is the highest that can be accepted as entirely consistent with with the safety of other road users. While there may be circumstances in which individual driving ability will not depreciate significantly by the time this level is reached, the committee is impressed by the rapidity with which deterioration occurs at blood levels in excess of 100 mg. /100 ml. This is true even in the case of hardened drinkers and experienced drivers. The committee cannot conceive of any circumstances in which it could be considered safe for a person to drive a motor vehicle on the public roads with an amount of alcohol in the blood greater than 150 mg. /100 ml.

#### 23. Reference #3

Report of Expert Committee on Alcohol
World Health Organization Technical Report Series No. 84
March 1954

#### Alcohol

The distribution is remarkably skew. In some countries, as much

as 37% of the alcohol consumption is accounted for by 2% of the population.

- 24. For this reason, the committee recommends that in the analysis of the composition of diets the amount of alcohol should be placed in a special category alongside protein, carbohydrate, and fat, and that in any nutritional survey attention should be paid to the distribution of alcohol consumption throughout the population considered.
- 25. Since alcohol consumption is generally compensated by a decreased intake of calories from other sources, there is a danger that the habitual use of large amounts of alcohol may lead to deficiency diseases caused by a low intake of protective foodstuffs.

#### 26. Alcohol and Traffic

Statistical studies regarding alcohol and road accidents

It is evident that with regard to the vital question as to whether or not alcohol is the cause of a road accident, a definite answer can seldom or never be given in the individual case. Official statistics regarding alcohol and road accidents in most countries probably show only minimum figures, and cannot without a number of precautions be used for determination of the role of alcohol. Official figures in most countries are based on the following:

- the number of road accidents officially reported;
- 2) the number of cases detected in which alcohol is involved.
- 27. The percentage of cases of road accidents in which alcohol has played a role, when obtained from the two items mentioned, is liable to all the uncertainty inherent in the total number of road accidents and the number of accidents in which alcohol is thought to have played some part. The actual percentages stated show a

wide variation from country to country.

28. In recent years, endeavors have been made to frame studies upon
the role of alcohol in road accidents so as to comply with
stringent statistical requirements. The committee considers
that such endeavors deserve encouragement.

#### 29. Clinical Methods

In the collection of statistics on the role of alcohol in road accidents, and in the enforcement of laws regarding alcohol and road traffic, methods are needed that make possible a decision as to whether the person in question can be assumed to have been under the influence of alcohol to such an extent that his driving abilities were definitely impaired.

- Taking into consideration the investigations performed in recent years on the effect of alcohol on different functions in laboratory experiments, the results of statistically designed practical tests on drivers, air pilots, etc., and the statistical evidence from the few adequate studies existing on alcohol and road accidents, the inference cannot be avoided that at a blood alcohol concentration of about 0.05%, a statistically significant impairment of performance is observed in more than half the cases examined.

  The blood alcohol concentration at which departure from the
- normal performance can be demonstrated is of course dependent on the sensitivity of the test employed, and in a specified test on the tolerance of the person in question.
- 32. The ordinary clinical tests used in forensic practice must, when compared with the tests used in the experimental work referred to, be classified as rather crude. They may thus lead to faulty conclusions as to the condition of the person examined, so that an individual with a high concentration of alcohol in the blood may be

adjudged sober, while an individual with little or no alcohol in the blood may be considered under its influence. For this reason, clinical methods cannot be relied on as the only means of deciding whether a person is under the influence of alcohol. Clinical examination is, however, of importance in ruling out injury or disease as the cause of the behaviour.

#### 33. Chemical methods

A number of methods for the determination of blood alcohol have been in use for many years, and have proved useful and reliable. Among those for the mico-determination of alcohol in samples as small as 0.1 ml, the method of Widmark has perhaps been the most widely used, the total experience comprising hundreds of thousands of tests. Its reliability in living persons, including diabetics, has recently been established by comparison with other methods, among them the specific alcohol dehydrogenase method.

Determination of alcohol in the breath must be considered a less reliable index of alcohol concentration in the organism than the direct determination of alcohol in the blood, so that small differences in alcohol concentration cannot be reliably ascertained in this manner. However, when for some reason blood alcohol determinations cannot be made, determination of alcohol in the breath, when carried out with appropriate precautions, provides an acceptable substitute. The ratio of concentrations of alcohol in the blood and urine is so influenced by factors of absorption and elimination that urine alcohol determination has a limited value, and should be used only as a supplement to blood alcohol determination. Alcohol determination in saliva has recently been introduced in forensic practice. Experience, however, is so far too limited to permit its value to be assessed.

#### 35. General remarks

Legal views on alcohol and road traffic vary in different countries and states. These differences in attitude probably originate from a difference in point of view on the question as to which of the following acts shall be considered to be liable to penalty; either the intake of a certain amount of alcohol possibly leading to impairment of driving ability, or the driving of a motor car in a state of impaired driving ability caused by the intake of alcohol.

- 36. In the first instance, the objective of the legislation is generally preventive, and more stress will naturally be laid on the blood alcohol concentration. In the second case, proof of actual impairment of driving ability in the particular individual is paramount; and more stress must be laid on the result of a thorough examination of function.
- Owing to the widespread consumption of alcoholic beverages and the increasing complexity of traffic, the necessity for an acceptable solution of the important problem of alcohol and traffic is obvious. Differences in attitudes toward alcohol, in the intensity of road traffic, and in the general concept of justice in different countries, make it apparent that a single solution will not fit all cases. Thus, the problem must, for the present, be attacked on a national level.

#### 38. The need for further discussion

Many of the problems upon which the committee has touched need for their satisfactory resolution the combined efforts of experimental workers and clinicians. There are certain subjects which can only be adequately dealt with at a meeting attended by both groups. The decision to place alcohol in a position between that of the addiction-producing drugs on the one hand, and habit-

forming drugs on the other, exemplifies the difficulty which arises from the attempt to draw a sharp dividing line between the presence and absence of addiction-producing properties in a substance.

Variations in the degree to which a drug shows each of many different properties must be taken into consideration and some of
these properties are indicated more by clinical, psychological,
and social effects than by experimental evidence from the
natural sciences. Further exploration of this matter would
necessitate a joint meeting of experimental workers and
clinicians, and the committee recommends that the WHO should
consider convening such a meeting.

40. Reference #4
List of Countries with Summary of Legislation on Alcohol and
Driving

Country	Subjection to Physical Exam	Subjection to Biochemical Tests	Alcohol Blood Level Limits
South Australia	adopted in practice	adopted with conse	ent -
Victoria	permissive	permissive	over .05%
Western Australia	permissive	permissive	over .05%
Austria	permissive	adopted in practice	. 15%
Belguim	-	mandatory	. 15%
Canada	-	permissive	-
Denmark	permissive	permissive	. 10%
Finland	mandatory	mandatory	. 075%
France	permissive	permissive	no prescribed level
Western Germany	mandatory	mandatory	. 13%
Iceland	mandatory	mandatory	.05%
Eire	permissive	-	no prescribed level

Country	Subjection to Physical Exam	Subjection to Biochemical Tests	Alcohol Blood Level Limits
Isreal	-	permissive	no prescribed level
Luxembourg	mandatory	permissive	. 15%
Netherlands	-	-	no prescribed level
New Zealand	mandatory	-	-
Norway	mandatory	mandatory	, 05%
Peru	-	mandatory	no prescribed level
South Africa	mandatory	mandatory	no prescribed level
Sweden	mandatory	mandatory	. 05%
Switzerland	mandatory	mandatory	, 10% on practice
U.S.A.	-	mandatory in 5 States, implied consent in others	over ,05%

# 41. Supporting addendum - comments on suggested recommendations; February 11, 1962 - General F. F. Worthington, Ottawa

I concur in all but make the following comments:

a) Re safety devices, and installation of seat belts in government vehicles. In view of the fact that the federal government is doing this now I believe that the next step is to recommend that all motor vehicles in Ontario should be required to have safety seat belts after a given date. The date selected must allow ample time for motor car makers to include this feature in their assembly line.

Also, it must allow for manufacturers to produce and distribute seat belts to meet the requirements of old cars.

Lastly, time to permit car owners, presently on the road, to have belts installed. The installation must be in

accordance with safety specifications laid down.

It will be recalled that when 'traffic indicators' became mandatory the time element was included.

 Re driver education. The high school idea is a step in the right direction but does not go far enough.

The complexity of highway traffic today will increase, therefore, every person in charge of a motor vehicle should be competent. "Driver Training Schools" is one answer providing the instructors are qualified by provincial government authority. Also that the course of instruction be laid down by provincial authority. The following advantages arise here:

- a) Schools would be properly organized and equipped.
- b) All new drivers would be trained.
- c) Suspect incompetent drivers would be sent to the school for training. There are many borderline cases on the road now that need correction.
- 42. Comments, February 12, 1962 Dr. R.A. Kennedy, Medical Officer of Health, Ottawa:

<u>Driver Fitness</u> - The use of the word 'impaired' will perhaps carry the connotation of 'drunk'. Presumably what is meant is physically or mentally handicapped and I suggest that some such phrase be substituted for 'impaired'.

- 43. <u>Safety Devices</u> I believe the Federal Government has agreed to install seat belts in its vehicles. If this is so, perhaps some praise could be imputed by writing ......'urges provincial governments to follow the excellent example of the federal government by installing seat belts....'
- 44. Apart from these, I think the recommendations are excellent.

#### HOME CARE PROGRAMS

- 1. Home care may range in scope from the simple provision of visiting nurse service in the home, supported by some medical supervision and limited auxiliary services, to a complex of co-ordinated services concerned with the total medical, nursing, restorative and socio-economic needs of the patient cared for in his home.
- After reviewing a number of home care programs, each one varying to a certain degree, the essential elements of such a co-ordinated home care program are medical, nursing, social services, and in-hospital facilities for patients under care who may require hospitalization. Almost as essential are such elements as physical therapy; housekeeping services; laboratory, x-ray and other diagnostic facilities; availability of appliances and sick room equipment, and access to consultants in the various medical specialties. Other elements that are desirable for a complete program are restorative services including occupational therapy, speech therapy, and vocational counselling; nutritional advice; and access to nursing homes and foster homes for placement of those who have no homes or whose homes do not provide suitable accommodation.
- 3. In order to be effective, these services must be brought together and organized into an appropriate structure. The pattern that has emerged most frequently in the programs presently in operation include:
  - a central administrative control responsible for the program and the policies under which it operates.

- a co-ordination and evaluation team, usually comprising a physician, public health nurse and medical caseworker, who are responsible for initial screening and for co-ordination of services and resources, periodic review and final discharge of the patient.
- a service team comprising members of various disciplines who are directly responsible for the health needs of the patient within the context of his home and family environment.
- 4. A home care program, when properly organized and operated, releases the complex diagnostic and therapeutic facilities of the hospital to those who need them and with no capital investment and with sharply reduced annual operating cost.
- Many long term patients require hospitalization only during the period of diagnostic work-up and intensive therapeutic effort.
  Others would not require hospitalization at all if care in the home were available. The progress of others might even be better in the home than in the hospital; in a suitable home environment many patients make rapid physical and mental improvement.
- not be confined solely to those in the old-age groups afflicted with metabolic and degenerative illnesses of long duration. Individuals of any age may be treated successfully in their homes. Nevertheless to date, organized home care has shown its greatest usefulness in meeting the health, social and economic needs of the segment of the population represented by the elderly chronically ill.

- 7. Home care services are not new. Almost two hundred years ago, dispensaries were established in several cities in the eastern

  United States, i.e. New York, Boston and Philadelphia, for the purpose of furnishing medicines prescribed by physicians who attended the sick poor in their homes. Later dispensaries developed into outpatient clinics for the ambulatory sick.
- As hospitals expanded and developed suitable diagnostic and therapeutic facilities, a system of medical and nursing care for the indigent in homes became relatively less important. This trend was accelerated by changes in cultural and social patterns, which are not restricted to the indigent population alone: smaller homes with few bedrooms, and smaller families; working wives and other female members of the family who formerly could be counted on to assist in the care of the patient; vanishing domestic help; and suburbanization. Changes in the practice of medicine including increased specialization and the disinclination of busy practitioners to make house calls, particularly in metropolitan areas, brought about greater use of the hospital. The pendulum is now swinging toward the home again, impelled by the necessity to develop new patterns of care to meet the needs of the people.
- 9. A pilot home care program was begun on a demonstration basis in Toronto in March, 1958, under a Federal Health Grant to the Local Board of Health and with the sponsorship of the Social Planning Council of Metropolitan Toronto, the Academy of Medicine and the Ontario Hospital Association. Home care programs may range in scope, and the Toronto program chose the following definition of the United States Commission on Chronic Illness:

"those organized programs having centralized responsibility for the administration and coordination of services to patients (in their homes) and for providing at least the minimum of medical, nursing and social services, essential drugs and supplies."

- The Toronto community-based program holds to the concept that
  the people of the community in or out of hospital are the potential
  clientele. The family physician is the key individual, the community's agencies are the serving force and the home is the site
  of an integrated comprehensive care.
- 11. Home care may be requested when, in addition to doctor's visits,
  two or more of the following services are requested:
  - 1) skilled nursing care
  - 2) physical and occupational therapy
  - 3) nutrition, social work or other desired consultation
  - 4) homemaking and housekeeping service
  - 5) diagnostic and laboratory facilities
  - 6) help in getting supplies and equipment
- 12. The established voluntary community health and welfare agencies now receiving support from United Appeal and other sources as may be available, give the services. The doctor requests what he thinks the patient requires in the way of services and equipment. These are arranged for and co-ordinated through the Home Care office, in the amounts required to meet the individual needs and the home circumstances. The Home Care Program is

designed to assist the patient to receive maximum benefits from care and rehabilitation in the patient's own home. All services are rendered under the direction of the physician.

- The patient pays the actual cost of services, but any patient who cannot meet the full cost pays as much as he can afford. The participating agencies have provision for adjustment of fee to suit the circumstances of the patient. Program funds may supplement services not provided for in existing arrangements.

  Payment is arranged directly between the patient and the agencies rendering the service.
- 14. The study began in March 1958, and in September 1958, a demonstration area was mapped out to provide a population of approximately 200,000. In relation to populations served in comparable home care programs, the number of referrals and admissions during the first year of operation was not out of line, although the admission numbered only 35. The average age was 58 and the age range of patients was four years to ninety-two years. Twelve were over seventy years of age; this represents almost one-third of the admissions and indicated the greater need for service for the older age group.
- Being a research project which offers a range of medical care services including those usually obtainable only in hospitals to persons ill in their homes, a basic objective of the Pilot Home Care Program is to determine methods and cost of furnishing services which will bring to selected patients continuous care and maximum rehabilitation in a home setting,

#### 16. Specific Objectives

- To clarify the nature and the need for extended services and explore the possibility of their development in the community for care of the sick in their homes.
- 2) To develop a co-ordinated service that provides intensive care for patients in their own homes through the use of existing services including medical, nursing and other allied services.
- 3) To obtain estimates of the cost of providing service to selected patients in their homes in lieu of hospitalization or to shorten hospital stay.
- To determine methods of operating a co-ordinated service in a community agency which will integrate the services required to provide adequately for the care of selected patients in their own home.

# 17. Medical problems fall into three categories:

- patients with acute illness which did not necessitate
   hospitalization and those convalescing from acute
   conditions following a period of hospital care,
- 2) patients with conditions of a chronic nature.
- 3) those requiring care during the terminal phase of illness.
- 18. The services required to provide as intensive care as was demanded
  by the individual need of each patient were arranged for and coordinated through the agency of the Pilot Home Care Program.

They were drawn from present community resources, but integrated through a central administration under the direction of the patient's physician. Payment is arranged directly between the patient and the agencies rendering the service. The participating agencies have made provision for adjustment of fee to suit the circumstances of the patient; program funds may supplement services not provided for in existing arrangements.

- 19. Some of the problems experienced in the first year, and still exist, include the gaps in available services. A major problem is still the one of the sufficiency of interpretation of the program to those who influence its use and growth. On the other hand, limiting the territory service has cut down the approaches to publicity. Another problem is the one of cost of service to the recipients of same, the medically indigent in particular. For some, a measure of service is provided through public assistance channels, medical care for example, drugs under certain circumstances, etc.

  For others, these provisions either do not pertain, or if they do, are not present in the same degree. In the case of the person hospitalized or hospitalizable, any of three forces may go to work:
  - 1) continuance of care in hospital if it can be arranged.
  - admission in some instances.
  - avoidance if at all possible of home care with its physician and related services, which to many seems costly no matter how small the cost may appear to the more fortunate.
- 20. During the second year of operation, 71 patients were admitted to the Home Care Program and once again the majority of these

patients were in the older group, i.e., over one half of the admissions were over 70 years of age. Increased use was made of commercial sources of services and supplies to fill the gaps in organized voluntary and official community agencies, both in the kind and the amount of services available.

- Physicians' services, including both home visits by private 21. practitioners, consultation with specialists and visits to outpatient department clinics totalled 400 contacts for 86 patients who had an average stay on the program of 89,4 days. This translated into frequency of visits denotes a spacing of one every 19 days. The above figure gives an inadequate picture of the medical supervision for patients. The policy of a minimum of at least one physician's contact per month was relaxed if the physician did not think such frequency necessary. Resistance was encountered in patients' reluctance to pay for a call from a doctor for other than emergency reasons. It was stated that rehabilitative services require periodic evaluation by the attending physician in order to give the necessary instruction to the workers providing the services. Accepting the premise that the quality of service rendered through a home care program depends on the quality of medical supervision, the time and effort expended in encouraging patients and families to secure the minimum amount of medical supervision was considerable.
- 22. During the second year, the Home Care Program served as an alternative to institutional care for 36 patients to the extent of 2,193 days of service. If the Home Care Program had not been available these patients would have had to remain

in hospital or other medical care facility, or for some, institutional care would have been necessary. During the second year 86 patients spent a total of 7,695 days on the Home Care Program.

23. The experience of the third year proved that the major sources of inquiries continued to be from persons who were giving direct service to patients, and admissions totalled 101 cases. This represented an increase of one-third over the rate of program growth in the second year.

# 24. Hospital Initiated Home Care Program

With the co-operation of the New Mount Sinai Hospital and the Toronto Western Hospital, the Home Care Program was expanded in September, 1961 to enable patients to leave the hospital sooner and to continue their care in the home, under the continuing supervision of the attending physician. The expanded program is an extension of hospital care and provides the comprehensive care the patients would have received had they remained in hospital for a longer time. The Home Care Program provides up to 60 days of home care. Additional days of care will be provided where there is evidence of necessity.

- 25. The Home Care Program provides, without charge to the patient, the following services as ordered by the attending physician and when necessary and directly related to the treatment of the condition for which the patient was hospitalized:
  - 1) Nursing visits by a registered nurse as often as is

medically necessary. Nursing care in the home includes administering drugs, changing dressings and other essential nursing care as provided by a visiting nursing service.

- 2) Physical and occupational therapy.
- 3) All necessary laboratory tests, x-ray studies, drugs, medicine and dressings as prescribed for and necessary to the condition for which the patient is hospitalized, but not drugs or supplies for other unrelated conditions. The services provided will be procured through either of the participating hospitals.
- 4) Hospital or sick room equipment when needed.
- Homemaking service will be supplied on a part-time basis. The duties of the homemaker include direct services to patients such as helping the patient in and out of bed, meal preparation and such other duties as the Home Care Program may deem necessary.

  This service will be used for patients whose families are not able to perform the service for them and the Home Care Program will determine whether such is necessary.
- When home care is considered for a patient, the attending physician discusses the possibilities of home care with the patient. If the patient agrees, the physician plans the patient's home care with the Hospital Nurse Co-ordinator of the Home Care Program the frequency of nursing visits, physical therapy, medication and other details that are required to provide continuity of care.

- 28. The patient is taken to his home and home care services instituted.

  A registered nurse will make her first visit either the same day or the next day, depending on the physician's orders. The nurses and therapists working with the patient continue to receive direction from the patient's physician who remains in full charge of the case. A Home Care Program representative also will visit the patient at home to check on other needs such as assistance with the housekeeping. Home care will end when it is determined that the patient has sufficiently recovered in the same way that it is determined that the patient is ready for discharge from hospital.
- Decause it has not been in operation long enough to evaluate. The goal of 300 patients for a two-year period was set roughly 12 per month. This goal is not being realized. Perhaps the main reason why this goal is not being met is because the program has been in operation only four months and something new always takes time to catch on. Another reason is that under the provincial hospital insurance arrangement patients who pay their premium are allowed hospitalization benefits at no charge. A patient might conceivably say "why should I admit myself to the home care program which would involve additional expense when this additional expense can be avoided if I remain in hospital?" Insignificant though the additional expense may be, it can be very important to many people.
- 30. A number of people feel they are more "safe" in hospital with the ready access to doctors, nurses, etc., than they would be

in their own home, when they are ill. They may feel reluctant to agree to the home care program for this reason.

- 31. One limiting factor is undoubtedly the attitude of the practising physician toward care in the household under the auspices of a central organization. He is concerned about the introduction of a third party into the traditional relationship between private patient and physician. He is reluctant or feels unqualified or does not have the time to assume responsibility for supervising the activities of a team of health personnel. He questions the need for time spent attending staff and evaluation conferences and keeping records and making reports. He may have evolved a pattern of practice that is based on the hospital rather than the home.
- 32. Both doctor and patient education is required before any hospital based home care program can hope to be successful. Hospital administrators and governing boards must also co-operate. As one woman who is closely connected with the Toronto Pilot Home Care Program said "what we need is a lot of very enthusiastic people." Indeed, there are some, but many more are required.

# 33. Services to Patients by Amount and Cost\*\* April 1, 1958 - March 31, 1959

Type of Service	Amount	Cost
Physician (visits)	121	\$605.00
Medical consultations (visits)	1	10.00
Clinic (visits)	35	119.00
Nursing: voluntary agencies (visits) official agency (visits)	751 15	2,066.75 n/c

# Services to Patients by Amount and Cost April 1, 1958 - March 31, 1959

Type of Service	Amount	Cost
Nursing:(Continued)  Registered nurses (hours)  Certified nursing assistants	72	126.00
(hours)	50	50,00
Social Service (contacts)	21	n/c
Nutritionist (visits)	3	10.00
Physio-occupational therapy (visits)	141	561.00
Physiotherapy (visits)	89	320,50
Speech therapy (visits)	3	15.00
Homemaking: Family service (days) Service to aged (hours) Other sources (hours)	249 1,061 1,744	2,241.00 1,161.00 1,632.40
Transportation: (trips) Car Taxi Ambulance	25 71 25	n/c 71.00 300.00
Appliances (items)	11	61.57
Loan Equipment (items)	33	n/c
Rental Equipment (items)	3	131.50
Medical Supplies * (items)	12	25.15
Laboratory Procedures (items)	3	n/c
Other:  Eye examination (visits)  Night sitter (hours)  Food supplement	1 36	5,00 36.00 - 25,00
Total		\$9,572.87

<sup>\*</sup> Medical supplies do not include medications

<sup>\*\*</sup>Toronto Pilot Home Care Program

# 34. Services to Patients by Amount and Cost April 1, 1959 - March 31, 1960

Type of Service	Amount	Cost
Physician (visits)	295	\$1,480.00
Medical Consultations (visits)	6	50.00
Clinic (visits)	99	346, 50
Nursing:  Voluntary agency (visits)  Official agency (visits)  Registered Nurse (hours)  Other (hours)	1,705 19 1,520 194	4,808.00 n/c 2,849.00 241.50
·	37	n/c
Social Service (contacts)	01	п/с
Nutritionist (visits)	1	5.00
Physio-occupational therapy (visits)	437	.1,921.00
Physiotherapy (visits)	122	436.50
Occupational therapy (visits)	10	44.00
Homemaking: Family service (days) Service to aged (hours) Other (hours)	58 2,824 5,764 1/2	580.00 2,819.50 5,205.65
Transportation: (trips)  Car  Taxi  Ambulance	41 342 52	n/c 364.70 624.00
Appliances (items)	25	410.84 #
Loan Equipment (items)	85	n/c
Rental Equipment (items)	15	260.25
Medical Supplies (items)	4	4.32
Medication *	1	24.75
Laboratory Procedures (items)	2	6,00
Other Chiropodist (visits) Occupational therapy supplies (items)	1	5,00 3,00 \$22,489,51

- # Cost does not include purchase price of 3 wheel chairs by two organizations and one family that is buying one on time payment.
- \* Medication does not include amounts purchased by patients, provided by the Department of Public Welfare or voluntary organizations.

# 35. Services to Patients by Amount and Cost (128 patients) April 1, 1960 - March 31, 1961

Type of Service	Amount	Cost
Physician (visits)	367	_
2 117 510 2001 (		
Medical consultations (visits)	1	-
	0.14	
Clinic (visits)	211	
Nursing:		4
Voluntary agency (visits)	2,843	\$8,503.00
Official agency (visits)	65	n/c
Registered Nurse (hours)	-	-
Other (hours)	526	424.25
(	-	
Social service (contacts)	70	n/c
		·
Physio-occupational therapy (visits)	489	2,236.50
•		
Physiotherapy (visits)	103	490.00
Homemaking:		
Family service (days)	69 1/2	
Service to aged (hours)	2,686 1/2	2,686.50
Other (hours)	9,382 1/2	8,963.83
Transportation: (trips)	•	,
Car	60	n/c
Taxi	607	636, 15
Ambulance	41	567.00
Appliances (items)	16	215.39
Appliances (items)	10	210.09
Loan equipment (items)	72	n/c
acus equipment (100mb)		
Rental equipment (items)	9	158,00
• • • • • •		
Medical supplies (items)	-	35.67
Medication *	-	1.50

## Services to Patients by Amount and Cost April 1, 1960 - March 31, 1961

Type of Service	A	mount	Cost
Laboratory proce	edures (items)	-	-
Other: Occupat	ional therapy supplies (items)	5	7.35

\* Medication does not include amounts purchased by patients, provided by the Department of Public Welfare or voluntary organizations.

#### APPENDIX #13

### AMBULANCE SERVICES AND TRAFFIC CASUALTIES

Report of the Cornwall Area Traffic Casualty Study

December 1, 1959 to November 30, 1960

(Booklet Attached)

APPENDIX #14

ONTARIO PHYSICIANS' DESK COMPANION

(Booklet Attached)

#### RESULTS OF QUESTIONNAIRE SENT TO BRANCH SOCIETIES

- Twenty-three replies to the questionnaire sent to 57 Branch
   Societies were received, seven of which were useless for purposes of tabulation. This represents a sampling of 28.4%.
- 2. To the question "we would like your opinion on present and future requirements of personnel for your area," it was difficult to determine in the sixteen replies whether or not the future requirements was understood to be x number more than the present requirement, or the total requirement.
- 3. A number of replies contained comments relative to figures listed and these comments will be reviewed at the end of this report.
- 4. General Practitioners: 201 general practitioners were listed as being presently required, and 288 listed as being required in the future. One reply stated no general practitioners were required for the future, and one respondent was unable to project future requirements.

5.		Present Requirements	Future Requirements
	Surgeons		
	General	25	36
	Orthopaedic	4	8
	Urology	5	7
	Neurology	5	1
	Cardiology	-	-
	Gynaecology	5	12
	Otolaryngology	6	11
	Ophthalmology	9	17
	Internists	9	10
	Cardiologists	-	1
	Anaesthetists	20	34
	Dermatologists		2
	Neurologists	3	3
	Psychiatrists	13	23
	Paediatricians	7	10

Pathologists	7	11
Radiologists	9	11
Obstetricians	8	12
Public Health Officers	8	12
Public Health Nurses	59	74
Interns	77	32
Nurses	516	906
Nursing Assistants	247	289
Nurses Aides	276	282
Dieticians	15	23
Physiotherapists	28	44
Occupational Therapists	12	11
Laboratory Technologists	55	70
Radiographers	31	. 34
Medical Record Librarian	16	22
Orderlies	56	82
Home Care Nurses	44	18
Homemakers	400	30
Social Workers	27	2
Acute Hospital Beds	3330	5313
Chronic Hospital Beds	1001	1795
Convalescent Beds	681	975
Nursing Home Beds	974	845
Mental Hospital Beds	405	1035
Homes for Aged	1270	2150
		=200

# 6. The following comments were submitted by branch societies of our Association and are appended for the information of the Royal

Commission on Health Services:

Improvements required to make the private practice of medicine
a more satisfying experience for the patient and the doctor:

- 7. Societv #1: The health service in this area could be improved by the following methods:
  - a) Providing chronic, convalescent, and mental hospital beds
     which are badly lacking.
  - b) Improving the shortage of personnel in our general hospitals

    particularly with regard to laboratory technologists and

    x-ray technicians. This might be achieved through

increased facilities for training of technicians as well as increased publicity with regard to opportunities and needs for such positions.

- c) Improving consultation service for practising physicians by obtaining the services of an ophthalmologist and psychiatrist in this area either on visiting or permanent basis.
- d) Establishing physiotherapy and pathology departments in the largest hospital in this area.
- e) Obtaining badly needed social workers who should be bilingual.
- f) Avoidance of encroachments by the public health department on private practice. The majority of doctors in this area feel that the emphasis in public health service should be put on the rendering of service primarily to needy people and providing it in places where it could not be provided by physicians in private practice. The local doctors' offices should be utilized and included in the public health program; in other words, whenever possible, the public health campaign should not detract patients from the local doctors' offices, but encourage them to receive the service there.
- g) Government services should be curtailed in places where established services are being rendered by private physicians, but in small areas where existing services are insufficient, government services should be increased.
- h) Government extension of diagnostic facilities at out-patient departments of hospitals and in doctors' offices might be acceptable if based on fee-for-service and in accordance with the current O.M.A. schedule.
- i) The lay societies, i.e. the Cancer Society, Society for

Crippled Children, etc., must not encroach on private practice by by-passing doctors. Their services are acceptable if they restrict their activities to education of the public and assistance to the medical profession under the physician's guidance.

### 8. Society #2

- a) General practitioners should be afforded full hospital privileges in all hospitals according to their capabilities and training.
- Bona fide refresher courses of one week or more should be deductible as an expense for income tax purposes.
- c) Deserving medical students from low and moderate-income families should be fully subsidized as long as they maintain their grades at universities.
- d) Interns and post-graduate doctors should receive adequate wages during training, i.e. on monthly basis comparable to pay for other jobs.

### 9. Society #3

a) In general the members of our branch society would like to partake of more post-graduate education and see their confreres do the same, but seem to yield to the pressures of time and practice. It was thought that a minimum standard in terms of hours-per-year would be a good idea.

## 10. <u>Society #5</u>

a) There is an urgent need for a school for one hundred deaf
children to serve Northern Ontario. At present the only
facility is in Belleville, and deaf children are not taken there
until they are six years old, by which time considerable
psychological trauma and backwardness is occasioned to

most afflicted children. There is a real need for a positive policy for the care of the deaf child of pre-school age. There is also need for a policy for the detection and care of hard-of-hearing children in ordinary schools.

- b) There is rapidly increasing difficulty in gaining hospital admission for patients. This has resulted from two causes:
  - i) Increasingly Sudbury is becoming a reference centre for cases that would otherwise (or previously) go to Toronto; these are drawn from Manitoulin, Blind River, Elliott Lake, Timmins, Sturgeon Falls, etc.
  - ii) The advent of the O. H. S. C. has greatly interfered with the normal pressures and balances in regard to hospital admissions. Present waiting lists at our three general hospitals are: Sudbury General Hospital, 345; Sudbury Memorial Hospital, 180 (excluding children), and St. Joseph's Hospital, 250 (150 - 400 over the year). This gives us a waiting list of 775 for some 725 beds.
- c) The increasing number of committees required for running hospitals is placing a frustrating strain on the time of busy medical practitioners. Thus, at the General Hospital alone, there are 14 committees, almost all involving medical men who are expected to participate in committee work at one or both of the other two hospitals, and/or the sanatorium, not to mention the District Medical Society, O. M. A. and lay-medical groups such as the Cancer Society, Retarded Children, Children's Aid Society, etc.
- d) The increasing tendency to divorce nurses' education and training from practical medical aspects towards administrative aspects is fast leading to an expensive man power problem. This is necessitating the training and hiring of nurses' aides and special nursing technicians to do

actual nursing procedures, while the R.N. is devoting her time to administration, form-filling, charting, etc. and is becoming of less direct assistance in the care and management of the sick. The whole orientation of post-graduate nurses' training is compounding this expensive error in emphasis, in which "Teamwork" is the euphemism used to cover lack of individual player participation.

- e) There is growing evidence that hospitals are being organized for the benefit of employees rather than for patients. Thus, it is insisted that nurses must have two days off each week, and since most of them want this at the weekend, there is strong pressure to close operating rooms on Saturdays. This is further adding to the cost and inefficiency of hospital services.
- f) The Long Stay Forms demanded by the O. H. S. C. are a nuisance and an expression of lack of trust in professional opinions and ethics a further example of the necessity for controls when the moral bases of society are undermined or abrogated.
- g) The advent of the O.H.S.C. has removed local autonomy from the hospitals; this leads to professional frustration, since much time is spent by medical committees discussing problems about which nothing can be done because of central O.H.S.C. control. Cases in point are:
  - i) the desperate plight of Sudbury hospitals for new and/or additional space for records, files, storage, x-ray and laboratory diagnostic facilities, all of which could now be well on the way to solution had autonomy and economic solvency not been removed from the hospitals;
  - ii) the inability to attract or hold senior technical personnel

because the O.H.S.C. has refused to accept in practice the salary scales for senior laboratory personnel as recommended by the Canadian Society for Laboratory Technologists. This has happened for the last two consecutive years at two of our three general hospitals.

- h) The profession should be granted practical recognition for care of indigents in hospital. Money is not necessarily sought, but since the various governments pay much lipservice to their responsibility for this group, it is at least to be expected that the same governments should acknowledge the efforts of the private physicians who discharge this much-vaunted public responsibility. Suitable recognition would be in the form of income tax credits,
- i) Inundation of the practising physician with all types of forms and certificates is placing an expensive and exasperating burden on medical men. So many of the normal checks, balances and responsibilities have already been removed from the public by various schemes (government and otherwise) that the citizen expects his doctor to act not only as physician, but also as agent, clerk, counsellor, confessor and go-between,
- j) The de-emphasis on the general practitioner has reduced his status in the eyes of the public, many of whom now regard him as inadequate to care for their real or imaginary ailments and tend to use him merely to gain access to specialist care and opinion.
- k) The gradual encroachment of public health office activities are further adding to this de-emphasis of the general practitioner, whose role as family physician is made much more difficult and frustrating thereby. Thus, young women who attend ante-natal and other such classes are actively

encouraged by public health authorities to bring their infants along for free immunization, etc. The result of this is that these people, who generally have prepaid insurance are discouraged from seeking a family doctor, or do so only when in need, and thereby deny the physician the possibility of being a true family physician. In short, the difficult problems the after-hours and night calls are left to the general practitioners, while the 9 - 5 public health people take the easy part of medical practice.

- l) It is manifestly unfair that convention expenses are deductible as a legitimate expense in income tax, yet if a physician is really keen and wishes to keep his knowledge up to date by attending post-graduate and/or refresher courses, he gets absolutely no income tax concession for the necessary and considerable expense involved.
- m) Government agencies are among the worst offenders in taking advantage of the private physician. Thus, in respect of members of the armed forces, D.V.A., R.C.M.P., and C.N.R. employees, the physician receives only 90% of the general O.M.A. tariff, and this only after completion of full case histories and accounts in quadruplicate. Federal government practice in the treatment of Indians is particularly bad; not only is the remuneration totally inadequate, but the agencies take every opportunity to renege on their responsibility for Indians by whatever loophole. They frequently argue that a certain Indian has not been back to the Reservation more than once or twice in the past year, and that the physician should regard said Indian as a private patient.
- n) Maintenance of nursing schools is becoming increasingly

costly. Furthermore, much time is required from the practising physicians in lecturing to student nurses. We already have two nursing schools in Sudbury, yet a third is contemplated and is being actively promoted. It is our belief that two nursing schools are adequate for this area for the foreseeable future; a third school is neither necessary nor desirable.

o) Northern Ontario, with a population of about 500,000, is badly in need of a small to medium-sized medical school that would graduate about 40 doctors annually. Sudbury which now has a university, and which is the largest and wealthiest community and has the largest medical staff (126 doctors) is the logical place for the location of such a new medical school.

### Society #7

- 11. a) It is our belief that the greatest need for this district is for chronic, convalescent and nursing home beds. The existing facilities for medical services have been greatly improved by P.S.I. as of August, 1961. It is also our belief that the private practice of medicine whereby the patient-doctor relationship is maintained will provide the highest standard of medical care. It would seem that where another party is more and more involved that the medical practitioner would of necessity be forced to spend more time with reports and other paper work to the detriment of his patient's health.
  - b) Post-graduate medical education has been greatly facilitated by the various clinical days and refresher course which have been made available. These courses might be more valuable if more of them dealt with specific fields rather than each one

trying to cover a diversity of topics. This has been greatly helped by the various special courses offered by the University of Toronto Alumni Association.

### 12. Society #9

- a) The increasing demand by the patient, or by the political parties reputing to represent his interests, for increased medical coverage will lead to a deterioration of the relationship between patient and doctor. This can not be prevented but may be modified by:
  - (i) any method which will ensure a patient staying with one doctor so that each may acquire a respect for the other;
  - (ii) the availability of good quality specialist services to help the general practitioner. The specialist who does general practice is a specialist by training but fails to improve through constant work with the difficult cases in his specialty, and is to be discouraged. Specialists should see patients by referral only.
  - (iii) Medical officers of health should make more personal contact with general practitioners, for their interests often overlap and could be of mutual benefit.

#### 13. Society #10

a) We realize that practising in Kingston is somewhat different than in other localities because this is a university centre, and both general hospitals in Kingston are teaching hospitals for Queen's University. This involves physicians in teaching medical students and interns, as well as attending teaching rounds. This, in conjunction with attending other hospital meetings, means the loss of a great deal of time which would ordinarily be devoted to practice. It was felt that this

- created a heavy burden on the doctor without adequate compensation.
- The community of Kingston, also because it is the university b) centre, seems to be adequately supplied with specialists, and perhaps undermanned by general practitioners. Because both hospitals are in a university setting, the general practitioners do not take upon themselves the care of complicated cases which we feel sure are looked after by general practitioners in other areas. This results in a very high rate of referral. The general practitioner on the whole is much over-worked, and as a result of this does not take a very active part in teaching or attending teaching rounds. It was our feeling that it would be advisable for a closer integration of practitioners and specialty services. In this way the general practitioners might be made to feel more a part of the hospital, and to take a more active part in teaching rounds, and attending other hospital meetings.
- c) With regard to the apparent surplus of graduates taking up specialty training it was felt that specialty sections might benefit by a survey of the country to estimate the need for different types of specialists, and hence adjust the number of doctors being trained to fit these needs.
- d) Group practice was thought to be advantageous in allowing doctors to have some free time to themselves, but realizing that this has to be on the basis of individual likes and dislikes.
- At the present time the Ontario Hospital Services Commission
   allows benefits only for those patients admitted to hospital.
   This, to our way of thinking, lends itself to over-utilization
   of hospitals in order to save patients money. We feel that

the use of hospitals could be greatly diminished by having allowances made for "out patient diagnostic services" which would prevent some patients from being admitted to hospital if adequate laboratory investigation could be done at no charge to the patient outside of the hospital. The other frustrating thing about the O. H. S. C. is that it will pay the cost of all drugs while the patient is in hospital, but not on an "out-patient" basis. We also feel this occasionally leads to patients being kept in hospital longer than necessary. Going even further, we feel it would be advantageous and cheaper for the government to provide other home care services such as home nursing or practical nursing. This probably would decrease the need for hospital beds, and not interfere with the health care of the community.

- f) It was felt that more refresher courses should be held in

  Canada, and perhaps this should be the function of the

  Royal College of Physicians and Surgeons.
- g) In regard to present and future needs for health services in

  Kingston, we felt that Kingston is adequately covered in most

  of the specialties, but there are not enough general

  practitioners, and future needs for both categories will increase
  as the population grows.

### 14. Society #12

- Need for medical superintendent. Present system cannot correct sloppy diagnosis and treatment and abuse of beds.
- b) More nurses, especially operating room staff. (Operating room is the temporary bottle-neck; bed shortage is the permanent bottle-neck.)

- c) More homemakers needed.
- d) About three interns needed now. The present load on doctors is heavy and in such areas as documentation should not be increased.
- e) Method to increase authority of medical administration in the hospital -- medical superintendent, full-time secretary and office space for chief-of-staff and president of medical society. Their present load will reach breaking point.
- f) Better control by admission and discharge committee to prevent bed wastage. Suggest patients pay a small fee for bed, e.g. \$2 daily. Assistance for A & D committee by chief of staff's secretary and interns mentioned above.
- g) Acknowledgement that the doctors are a trained professional body in immediate and permanent contact with the sick of the community, however other conditions may change. They work long, hard, tense hours, and this fact will never be changed in the practice of medicine at its best. Deterioration of their present status with regard to their authority or remuneration will affect the community adversely.
- More general practitioners and more resident hospital staff needed.
- More acute beds needed to reach optimum of 1 per 100 of population.
- j) Need for coverage of out-patient laboratory and x-ray services and emergency care not requiring admission. Suggest in acute hospitals reducing the admissions for so-called diagnostic work-up. Provision for consultation on acutetype patients on admission and if patient is deemed to need hospitalization.

- k) Patients have no real criteria of judging efficacy of medical care. In all cases the psychiatric assessment and positive self-help should be brought to bear and the patient given real teaching in understanding himself and his disease.
- Number of beds may need doubling but out-patient departments, with all medical groups using and co-operating with the department, must be enlarged. Doctors must gradually do more of their work in the hospital, and home visits should be gradually eliminated. Home care is not practical anymore.

## 15. Society #13

- a) Present facilities are adequate in this area except for a shortage of hospital beds.
- b) An extension of diagnostic facilities under the aegis of O.H.S.C. would improve our facilities provided this would be accomplished without compromising the position of independent pathologists and radiologists.
- c) Extension of O. H. S. C. insurance or provision of a similar scheme to pay nursing home rates for people on marginal incomes (i.e. those just above indigent category) would help to lessen the pressure from these people and their relatives on physicians to admit them to a chronic hospital.
- d) Income tax exemption for post-graduate courses would encourage more practitioners to keep up to date.

### 16. Society #14

a) The one thing that is most urgently needed here, and of course this must come from local initiative, is a county medical health unit. There is considerable difficulty in getting the doctors to take on part-time M.O.H. duties, for which they are not specially trained. The municipalities are not keen about

- putting out enough money to have these medical officers of health operate in an efficient manner. A county-wide medical health unit would be of great benefit.
- b) We feel there is a certain amount of dissention between the general practitioner and specialty groups. In spite of attempts to iron out this and prevent it, it keeps cropping up from time to time.
- c) The general practitioners feel that hospital privileges are
  being restricted unduly and probably there is a slow, but
  steady, encroachment on their privileges in a hospital,
  We feel there is a definite problem of integrating the
  general practitioner into hospital practice, taking into
  consideration the requirements laid down by the accreditation
  committee.
- d) It is quite obvious that the Ontario Hospital Services

  Commission is gradually encroaching on the autonomy of
  local hospitals. This has been brought to our attention,
  especially by the inability of hospitals to pay the salary they
  think they need to pay for certain members of the staff. The
  salary questions are always reviewed very critically by the
  O.H.S.C. and there is a great tendency by the O.H.S.C. to
  want to level the salaries paid. It is going to become more
  and more difficult for hospitals to pay any salary out of line
  with the average for personnel with greater-than-average
  ability and of greater-than-average value to that particular
  hospital.
- e) As a strictly local problem, we find that the large employers of labour do not always contact the medical profession when negotiating health care benefits with their employees. We realize that this is their business but, as we provide the

health care, we think it would be only a matter of courtesy for them to discuss it with us, or at least to inform us as to what is going on. We have taken this up with the chief offender in this matter on more than one occasion, but so far have had no response.

## 17. Society #15

- a) Shortage of consultants in our area of specialists in ear, nose and throat, ophthalmology, paediatrics, obstetrics.
- b) Excessive work entailed by commercial insurance schemes.
- c) Confusing drug nomenclature and pressure from drug salesmen.
- d) Shortage of hospital beds and other hospital facilities.
- e) Suggest training of fewer surgeons and more of specialists mentioned in (a) above, and persuading them to practice in the smaller centres.
- f) Suggest increase P.S.I. enrolment and make other insurance companies give similar service to P.S.I.
- g) Have a Canadian version of "The Medical Letter" and make more doctors aware of it.
- h) Assist municipalities in increasing their hospital facilities.

## 18. Society #18

- a) We feel we are reasonably fully staffed except in the matter of a home for the aged. In this matter we feel there is a need for 90 beds. There are plans at present by which these beds will be supplied, we hope, in the near future.
- b) There is also a need for social workers; but of more practical benefit, would be a measure to improve some of the substandard housing conditions present in the community.
- c) We feel the government could take more interest and pursue practical measures to improve the public health of

the community.

### 19. Society #20

- a) Our group felt that the present doctor-patient relationships were good. Complaints are minor on both sides. Most doctors feel patients are more demanding than necessary. We feel that patient training and avoidance of an allinclusive health plan will keep this controlled.
- b) Patients sometimes complain they cannot get their doctor. Part of the answer is patient training. Part is improved care on the part of the doctor in arranging coverage during his absence. Area coverage on holidays, etc. helps answer this as well.
- C) Out-dating may occasionally depreciate the doctor's service.

  Hospital staff self-supervision tissue committees and

  credentials committees help control this. A further method

  of improvement would be greater encouragement towards

  refresher courses; participation for all phases of practice;

  encourage membership in College of General Practice where

  membership requires regular hours spent in refresher

  training; and income tax deductions for expenses in all

  refresher courses.

### 20. Society #21

a) Generally speaking, we have an adequate number of doctors in practice in this area to care for the needs of the population; there are probably a few more than necessary in some categories of specialists. Future requirements will be related to population growth. It is felt that more ophthalmologists will be needed if they are going to do more of the refraction work; there are an adequate number for

surgical care.

- It was felt that too many specialists are being trained. In the surgical specialties, it was felt that many of the trainees should receive a broader training, so that they could go to smaller centres, e.g. to work in a small centre a surgeon should be able to do common procedures in general surgery, orthopaedics, gynaecology, and urology. Junior interns should be more available to hospitals outside the teaching centres, and return to the teaching centres for advanced training. There was some feeling that all aspirants to a specialist degree should have at least one year in general practice at some time prior to completing their training as specialists.
- c) The medical officer of health here feels there should be, for this community (Hamilton only) himself, a deputy, and four district health officers. At present there is only one district health officer plus one doctor in chest work. There is one psychiatrist at present; at least one more is required now and this need may expand.
- d) It is felt that with planned new construction, there probably will be a sufficient number of active treatment beds in this area for the next few years. There is a need for more institutions to provide domiciliary care,

### 21. Society #22

a) The medical requirements for Russell County are quite fair at present, and there is no likelihood of increased population the Ottawa and Cornwall hospitals have been well able to provide the necessary accommodation.

### 22. Society #23

'Whereas, it has been shown by figures released by the Ontario Hospital Services Commission that the Municipality of Metropolitan Toronto is grossly short of active treatment hospital beds, viz. by approximately 20% of the requirement, and that present building programs will not meet the growing need:

and wheras it has been decided that that provision in Ontario of hospital beds is a local responsibility;

and whereas, it such a large area, it is patently desirable that the location and number of hospital beds shall be added according to a proconceived plan;

and whereas it has been the common experience of physicians in Metropolitan Toronto that it is often impossible to admit a needful patient to hospital, and that there are frequently delays which work against the patient's welfare.

Be It Resolved that the members of the medical profession of Metropolitan Toronto make it known to the Council of Metropolitan Toronto that they cannot, under the present circumstances, give the best medical attention possible, and that they earnestly request the said council to make planning and financing of hospitals a municipal concern!

## ONTARIO MEDICAL ASSOCIATION - SECTION ON PSYCHIATRY

"What are the implications of these bold ideas? They imply nothing less than the elimination of by far the greater part of this country's mental hospitals as they stand today. This is a colossal undertaking; not so much in the new physical provision which it involves as in the sheer inertia of mind and matter which is required to be overcome. We have to strain to alter our whole mentality about hospitals and about mental hospitals especially. Building hospitals is not like building pyramids - the erection of memorials to endure to a remote posterity. We have to get into our heads that a hospital is a shell, a framework, however complex, to contain certain processes and when the processes change or are superseded, the shell must, most probably, be scrapped and the framework dismantled. The old Roman virtue of "pietas" becomes a vice when it is directed towards a hospital building".

(Extract from a speech by Mr. Enoch Powell, Minister of Health, United Kingdom, when opening the Annual Conference of the National Association for Mental Health in March, 1961.)

### 2. RECOMMENDATIONS

1.

Since mental illness is a serious health problem, we recommend that:

- 1) Research programs be enlarged.
- 2) Priority be given to out-patient psychiatric services.
- There be increased facilities for training of all professional personnel.
- There be no disparity in treatment of mental and physical illness.
- A hospital or institution for the mentally ill be included under federal Bill 320, the Hospital Insurance and Diagnostic Services Act.
- 6) All prepaid medical insurance plans should adequately cover

- mental illness.
- Medical staff of a psychiatric facility should operate under by-laws similar to general hospitals.
- 8) Rehabilitation should be fostered.
- The problem of old age should be dealt with more in the community.

# 3. SUMMARY

Since Confederation, the mentally sick citizen has been dealt with as the public has demanded. In the past, he has been "put away" - out of sight and out of mind - in large, isolated buildings, known first as lunatic asylums and now as mental hospitals. Since the end of the First World War, notable advances have been made in understanding and treating mental illness, and communities are beginning to take an interest in their mentally and emotionally sick members, and to realize that they require medical treatment.

- 4. Because of the numbers involved, the disablement induced, the cost of care, and the gaps in our scientific knowledge, mental illness is the most serious of all health problems.
  - Research programs must be enlarged and talented physicians
    and other scientists must be attracted. This will benefit not
    only psychiatry but general medicine as well.
  - 2) In the planning and development of psychiatric services, priority must be given to an expansion of out-patient facilities. It is estimated that 75% or more of the acutely mentally ill who receive intensive treatment in community facilities will not require costly hospitalization.
  - 3) We require increased facilities for the training of all professional personnel. This includes nurses, psychologists, social workers, occupational therapists, and others, as well as psychiatrists.

- and physical illnesses. A sick person should not be penalized if his illness is called mental or emotional. He should receive adequate treatment close to his home.

  Psychiatric facilities should be closely related to the general hospital, and be part of a hospital centre. There should be more community interest in psychiatric treatment, possibly beginning with the formation of a local advisory board.
- As long as the mentally sick people are treated by a governmental hospital and the physically ill by a community hospital, both the patients and the public will not accept mental illness as comparable to physical illness. We believe that psychiatric services should be included under the Hospital Insurance and Diagnostic Services Act, as are physical health services, so that this distinction will gradually disappear.
- All prepaid medical insurance plans should adequately cover mental illness treated privately, in general hospital, or in mental hospital. For the past three years, mental hospitals have been discharging the "residents", and retaining as patients only those who require psychiatric care, and thus would be eligible for insurance plan benefits. Six to eight weeks in hospital is the average time spent by a patient with an acute mental illness.
- 7) There is a shortage of psychiatrists. To attract medical students and graduates to this specialty will require:
  - Full status as a specialist, which implies full
     acceptance by the profession and an income equal

- to other specialists.
- b) Salaried and part-time positions should be competitive, and the medical staff should operate under
  by-laws similar to general hospitals. Planning
  should begin to effect a gradual transition from the
  present system to the general hospital system.
- No further construction of isolated psychiatric
   facilities should be considered.
- 8) Rehabilitation should be fostered through half-way houses, hostels, sheltered workshops, and day and night hospitals.
- 9) The problems of old age should be dealt with more in the community, by the provision of home help, "meals on wheels", subsidized laundry services, etc., and the provision of hostels and small homes.
- A striking degree of similarity may be traced in the history of the care of the chronically sick and disabled and the care of the mentally and emotionally ill. Patients suffering from all these disorders have at some time been cast out from society or have been segregated in a variety of low-standard institutions. The changes which have taken place in the care and treatment of mental disorders in the past 200 years have been enormous.

  During this period the word "madhouse" gave way to the word "asylum", suggesting at least an increase in shelter and comfort. "Asylum" has given way to "mental hospital" in recognition of the fact that ideas of care and treatment have replaced notions of confinement and coercion.
- 6. Until now improvement in the care of mental patients has not kept pace with changes in the lot of the physically ill. This is to be seen, for example, in the deliberate geographical distance

still set between centres of population and the mental hospitals which sever them. That public attitudes which initially created such distance can be changed has been pointed out by Roberts (1) who, in his report on the Mental Health Services in Britain, has stressed the fact that the community can be led to take an interest and even some pride in its local mental hospital. In any case it is certainly known that geographical isolation leads to social isolation which, in turn, may lead to disorders of behaviour at least as crippling as those which brought the patient to hospital (Barton, 2). Mental patients no longer may be chained up; the more enlightened hospitals may not even lock them in. It is, however, just as iniquitous that they should be shut out of the community. In fact probably the most hopeful and exciting developments in the care of the emotionally sick lie in treatment within the home, rather than the hospital environment.

7. With these considerations in mind it is suggested that a new assessment should be made of existing facilities and of present and future needs of mental health.

### 8. Existing Facilities

Existing facilities are diverse and multiple comprising:

- 1) Mental Health Clinics and Out-Patient Services:
  - (i) 25 provincial mental health clinics, which dealt with 16,802 patients in 1960, of whom 42% of new patients were under the age of 17 years.
  - (ii) General Hospital Out-Patient Clinics
    - a) Municipal: Three full time, seeing 1,852 patients in 1960;
    - b) General Hospital: Five of these operated full time out-patient services and 1,454 patients

were seen in 1960. Three of these were specifically for children and account for 830 patients.

### 2) Community Services:

- (i) Municipal: two are administered by a lay board, others by a board of education, a family court and a provincial research foundation, and together saw 7,019 patients in 1960;
- (ii) Family agencies which provide a certain amount of guidance and counselling.

### 3) Private Practitioners

- (i) Private psychiatrists: There are approximately 70 in private practice, many of whom have other appointments in addition. No figures of the total number of patients seen are available but these are likely to be considerable;
- (ii) General Practitioners: The family physician is still the first agent to be called on in cases of ill-health. If a significant number, if not a majority, of all those he sees are suffering from either primary or secondary emotional problems then his role in both treatment and prevention of psychiatric disease is an extremely important one. His present training, however, does not adequately equip him in this area, and it is likely that he will require organized psychiatry to carry a significant portion of this load for at least another generation.

### 4) Day Care Facilities

In four mental hospitals: Ontario Hospitals at New Toronto,

Cobourg, Woodstock (O.H.) and Toronto Psychiatric Hospital.

### 5) In-Patient Facilities

- (i) General Hospital Psychiatric Units: 531 beds in 17 hospitals (only 13 were operating in 1960) and,
  - 4,438 patients were admitted, and 4,387 were discharged.
- (ii) Private Psychiatric Hospitals: 500 beds in eight hospitals - 102 of these in two hospitals are for mentally retarded children.
- (iii) Mental Hospitals and Schools: 20 in number with 23,150 beds
  - 8,765 patients admitted ) 6,735 patients discharged ) 1960 380 beds / 100,000 population

### 6) Rehabilitation

Most provincial hospitals maintain after-care facilities.

Fourteen hospitals have out-patient departments, and after-care arrangements are becoming more and more a part of the social services available in each community. Sometimes the patient will be cared for by his own private psychiatrist when he leaves hospital,

Some 255 boarding homes (foster homes) are used by the mental hospitals to look after 1,165 patients. A number of these are used as "half-way houses" in which the patient lives until he gets employment and is re-established in the community.

The Ontario Department of Health recently created a rehabilitation department to provide training and job placement for suitable convalescent patients. Some hospitals have industrial therapy departments which provide help in assessing vocational possibilities and in laying down

improved work habits.

Residential units have been established in most hospitals to care for the group of patients who no longer need psychiatric care, and who could be cared for in a country home or nursing home, if such were available.

- 9. From this description of existing facilities it can be seen that a varied and comprehensive service is provided to the public. Indeed its very success is reflected in the greatly lessened need for inpatient beds than was predicted a decade ago despite a population increase beyond expectations. Nevertheless, although such service encompasses both diagnosis and treatment it does not vet embrace the principles of continuity of care enunciated in the report of the committee of Mental Health Services of the C. M. H. A. (3). This has stressed how little is yet being done in the sphere of prevention which must surely be the ultimate aim of the continuum of care provided by the therapeutic team. There is evidence to suggest that our ability to produce remission and discharge from hospital is not at present matched by an equal ability to maintain the discharged person functioning in his environment. Such a failure may reflect in part inimical social attitudes.
- 10. If indeed there is room for a fresh therapeutic attack on this problem it lies in the relation of mental health facilities to one another and to the community which produces the mentally ill. Existing facilities are not organized to best advantage in that they are neither closely co-ordinated with one another nor integrated with the communities which they serve.

## 11. <u>Improvements to Mental Health Services</u> Organization

It is suggested that full integration and co-ordination of the existing series of services be achieved. The number of parallel but non-communicating facilities clearly must be reduced. Improvements could only be brought about either by an even greater degree of governmental control or, preferably, by some other organization with fiscal autonomy and control. (e.g.: The Hospital Services Commission).

- The arguments against central government control are numerous 12. and have been succinctly marshalled in a number of committee reports. These have pointed out that all previous recommendations concerning mental health have clearly indicated the desirability of establishing community hospitals and services in the truest sense, which would be funded and organized in the same way as general hospital services. As mental hospitals function at present their geographical and administrative isolation make continuity of care and community and family links difficult to ensure. In addition, one standard of care may obtain in a general hospital run by a local board of governors while another very different standard may apply to a mental hospital run by a distant governmental organization. These facts inevitably colour the public's understanding and attitudes to the afflictions of mind and body.
- The consensus is that the mentally ill are at a considerable disadvantage in comparison with the physically ill because of this.

  Since it has been clearly demonstrated that communities can successfully establish, maintain and operate general hospitals it must only be a matter of time before they do the same for psychiatric hospitals. The splendid resources of general

- hospitals would then become available to psychiatric patients to whom they are at present denied.
- 14. It has been pointed out also that although the total cost of such facilities may be greater, the cost to government is not necessarily so. The typical example of the Toronto General Hospital deriving \$6,649,072 of its income from the patients themselves and only \$1,127,174 from the Ontario Government for treatment and maintenance in 1958 may be cited in support of this contention.
- 15. It is concluded that there is no logical reason for the state to continue to operate almost all institutions for the care of the mentally ill when these other better facilities are potentially available.
- A further argument against any increase in central control is the increased difficulty in local executive action to which this commonly leads. Not only may this stifle initiative but it can also give rise to a paresis if not a paralysis of action when communication at the local level can be made only by going up through the whole chain of command and back down again.
- An example of the success of an alternative form of organization has been provided by the British National Health Service. In this system as Roberts (1) has pointed out, committees of management are under the general direction of regional boards and to a far lesser extent under the central offices of the ministry of health.

  Moreover, the methods of budgeting and financial control in the form of block grants provide far greater leeway. Although the budgets are prepared and approved as line grants, if a hospital saves money on one item it may use such savings in other ways with only nominal approval of the regional board.

- 18. If psychiatric services, like other medical ones, were based on local general hospitals, then community services embracing rehabilitation, family agencies and geriatric home and institutional care would create a form of integrated care which psychiatric services in isolation seem unlikely to achieve.
- 19. It is only when a community accepts and realizes its responsibilities that it takes action to deal with them. This is perhaps best illustrated in the case of the problems of senescene. Here the combination of social, physical and psychic morbidity call for a range of consultative and therapeutic agencies which no single resource can hope to meet. However, as long as large numbers of old people are sent to provincial mental hospitals in default of other solutions, the problems presented by an aging population are unlikely to be reduced. First admissions to such hospitals of patients over the age of 65 have almost doubled in the past decade and at present constitute over one-fifth of all new admissions. In a steadily aging population this would seem neither a good nor economic use of mental hospitals, nor their personnel, nor does it seem the best way to deal with a large part of human unhappiness.
- 20. Important gains in on-the-spot emergency or peripatetic treatment, day-care and follow-up treatment might also be expected to follow a change of emphasis in the organization of psychiatric facilities that would ensure local interest.

## 21. Personnel

The Ontario Mental Health Division employs 230 physicians in hospitals and clinics. According to A. P. A. standards (which are minimal and not optimal) there should be 460, double the present number.

- 22. The present 138 social workers are only one-third as many as are required now.
- 23. There are 637 registered nurses employed; there should be 1500.
- 24. There are only 38 registered occupational therapists; the absolute minimum should be 100 (200 by A. P. A. standards).
- 25. There are 88 psychologists with an estimated need for a minimum of 115. Change in the professional standards of the province may render many of the latter inadequately qualified.
- 26. These figures will all advance by 25% (estimated population increase) by 1971.
- 27. An increased emphasis on rehabilitation services is likely to create the need for even greater numbers of psychiatrists and social workers.
- Psychiatrists must be recruited from those physicians who already have made a vocational choice and thus are committed to certain expectations. The attractiveness of a career in this field is likely to depend upon status, reward and autonomy and the interest of a diverse job. It has seemed that doctors who have made a career of psychiatry have suffered in contrast with the other specialties. The young physician beginning his career is especially sensitive to such pressures and likely to swing away from a low-status choice.
- passivity of governmental employment and the over-aggressivity
  of the private psychiatrist each help to create an unattractive
  image for the possible recruit. It has further been said (1)
  that a desire to protect the mental patient may have led to
  over-protection of the staff with consequent loss of initiative.
  The result has been that medical positions in the Canadian mental
  hospital field have become unattractive, with a continued flight

Critics also have pointed out that the twin evils of over-

29.

of personnel either to private practice or to the United States. In 1960 the permanent emigration of 245 physicians born and educated in Canada deprived the country of the equivalent of 28% of all physicians graduating in that year, or approximately the whole graduating classes of the Universities of Toronto and McGill. Salaried physicians in the U.S. receive 50% to 75% more than their Canadian counterparts. Nevertheless this flight has been motivated not only by the desire to make more money but also by the hope, all too often realised, of gaining greater personal and professional satisfaction.

- There is little doubt that the professional development of a psychiatrist is fostered by diversity of practice. Many full-time hospital psychiatrists deal only with a particular inpatient service, often with patients of one sex, over many years, a fact which imposes severe restrictions on their own flexibility and ability to engage in any other perhaps more comprehensive programs. Moreover, the physician employed on a full-time salary particularly when there is fairly heavy commitment to a pension fund after a number of years, may not always be entirely free to express even constructive criticism of the setting in which he works and upon which he is dependent.

  Private practice may impose similar but different limitations of which professional isolation may be one, and difficulty in
- 32. What is needed is the creation of an opportunity to work in a number of settings, encompassing a broad segment of the range of psychiatric service. This may be made possible by sessional remuneration although the choice of full-time employment still would be available. The sessional worker should not be

following patients through hospital another.

penalised and to ensure this, proportional superannuation,
vacation and sick leave should be provided. In both full-time
and part-time employment the pension plan should be transferable
and independent. Existing pension plans discourage physicians
from leaving the service and thus impair their freedom of choice.

33. Vacancies should be advertised and filled by open competition.

## 34. Physical Facilities

Most of the present mental hospitals are large and isolated. If and when these become obsolete they should not be replaced. They might be used for other purposes but are ill-suited for the community-oriented psychiatry of the future.

- of care for the mentally disordered in which most of the patients will go on living at home while under treatment. They would gain the benefits of psychiatry through home treatment, day or night hospital, or short in-patient stay. This would decrease the danger of desocialisation and aid the integration with other medical services. It is desirable then that new hospital space should be closely associated with general hospitals, preferably being part of the same physical setting. The requirements of psychiatric care can be dealt with by suitable architectural planning. In some cases this facility might be merely a psychiatric ward and in others a number of wards or a wing of a general hospital.
- 36. There are positive advantages in the physical association of psychiatry with general medicine. Promixity enables the sharing of services. Thus the occupational and physical therapy departments and gymnasiums of the modern general hospital become available. Medical and surgical personnel and facilities

are at hand. Sterile and pathological services, heating, laundry and food supplies can be dealt with within one setting instead of being duplicated in different hospitals. Inevitably such changes will achieve both improved efficiency and economy.

37. In all instances there should be adequate provision for child care, day and night care, recreational, occupational and rehabilitation programs. Psychiatric out-patient and emergency services would be provided in general out-patient and emergency departments. Such a total service also would provide hostels, half-way houses, sheltered workshops and peripatetic community teams, Such psychiatric centres, whose size would depend upon the density of population (a figure of not greater than 300 beds is advocated), might serve as a co-ordinating focus for all the facilities in the neighbourhood. Space for geriatric patients in small hostels and residential homes would be a pre-requisite of this kind of comprehensive service. Many patients at present cared for in residential units attached to mental hospitals more properly might be regarded as the responsibility of the Ontario Department of Welfare.

### 38. Education

The training of the professional personnel concerned with mental health always must be vocationally directed. Such a clinical orientation requires a comprehensive service setting, and this training, itself based on learning through doing, in turn provides patient care.

39. There are thus good arguments for providing the fullest physical facilities and for securing these with adequate funds. Few medical schools or universities have yet accepted the full responsibility

- for graduate training in the mental health field nor are they financially able to do so.
- 40. In medicine there is a need for increased instruction in psychiatry
  early in the curriculum. This is best done in small groups on the
  medical and surgical wards which inevitably makes greater demands
  on personnel.
- The important health aspects of such training need to be recognized by direct grants to the university medical schools from health rather than educational budgets. Such investment would secure the double benefit of service and education.
- 42. These proposals would be equally germane to the training of all para-medical professional personnel required in the mental health field. In this area there are even greater shortages.
- 43. Greater governmental support should be given to those few universities that undertake the graduate training of psychologists to work in the mental health field.
- 44. At least three new schools of social work are required with a revision of present courses toward a greater psychiatric orientation therapy.
- 45. Degree courses in occupational therapy which are separate from physiotherapy should be provided at two or more universities.
- 46. All graduate training programs should make research opportunities available to their candidates. How far this should be mandatory remains controversial but undoubtedly the professional training of the psychiatrist has suffered in comparison to that of his psychologist colleagues whose training, as in other scientific disciplines, makes research a prime requirement.
- 47. There is a general consensus that exposure to research is useful and in order to make this possible all university

departments may need to expand in this area.

## 48. Research

So far as psychiatric research itself is concerned, two major sets of requirements exist, for funds and facilities.

- 49. Funds: In estimating financial requirements one basis for calculation would appear to lie in the decision about the size of that part of the gross national product which should be spent on psychiatric service and research, and how this should compare with analogous expenditure upon physical illness. If both direct and indirect costs of health care are considered it would appear that the cost-ratio of psychiatric research to service is approximately 1-to-700 in contrast to the 1-to-100 ratio obtaining in physical medicine. This disparity between mental and physical health seems somewhat unreasonable.
- 50. Since psychiatric illness involves far longer lasting morbidity than physical disease, with an associated decrease in productivity, its cost assumes major importance in the economic life of the country. This would seem a compelling reason for directing more funds into psychiatric research.
- of funding and tenure is essential. Again flexibility of professional opportunity should be available so that the worker can transfer to clinical work if he should so wish and, if need be, back to research without penalty. Sessional research payment and pension funds would facilitate this.
- Facilities: Two principal kinds of research facility seem to be required. Firstly, there must be centres sufficiently staffed and equipped for the securing and assimilation of research data.

  Secondly, there must exist the means of dissemination of in-

formation.

- of research institutes which preferably would be in the hospitals and associated with university departments. Research should be given authority in its own right. Thus the director of such research should be responsible administratively only to the highest authority in the organization in which he works. For example, in the case of a mental hospital, the research director should be responsible directly to the superintendent of that hospital. Otherwise research activities come to be tolerated only "on sufferance", even although it is known that without psychiatric research the actual care of the mentally ill may neither be further evaluated nor improved.
- The second function of the dissemination of information can be achieved only by the establishment of at least one first-class psychiatric library. No such facility exists in Canada today.

  This might best be conjoined with the setting up of a central national medical library with, for example, the most adequate possible microfilm and other equipment available so that information might be transmitted rapidly whenever and wherever it was required.
- 55. Given that these two kinds of requirements are fulfilled it is

  fair to assume that germane and relevant research investigations

  would be undertaken.

## 56. Finances

If changes in the organizations of mental health care are to be contemplated then consideration also must be given to the possible cost of such changes. It might be feared, for instance,

that reorganization of these services to bring them in line with general hospital practice would also increase their cost to a similar level. It is well to recall here Ewalt's comments with regard to the economics of mental illness (5). He points out that when we are considering the cost of providing the optimal care for the mentally ill we must ask ourselves which we can best afford -- the expense in dollars or the price in human misery. In any case we must recognize that even if we reduce the direct costs of providing service we may, in fact, thus be increasing the indirect cost to the nation created by losses in the productive power of that large segment of the community who will, at some time or another, suffer incapacity due to mental illness. The incapacity of these persons may be prolonged because of the lack of appropriate facilities, a lack itself created by the desire to effect more direct savings. Thus it is true to say that a nation pays the price of mental illness whether or not it finances the direct cost.

- For an initial increase in expenditure on mental illness might thus be expected to achieve a substantial over-all saving in the long run.
- 58. With these considerations in mind it is of interest to examine

  how much mental illness already costs Canada. Estimates may

  be derived regarding,
  - 1) Direct annual costs, including beds and service;

2) Indirect annual costs, including losses to industry.

## Direct Costs

a)	Running mental institutions	\$ 100,000,000
b)	Capital expenditure on institutions	25,000,000
c)	Running general hospital psychiatric beds	10,000,000
d)	Cost of care of patients seen in general practice	50,000,000
e)	Medication given outside hospital	5,000,000
	Total direct cost	\$ 190,000,000 p.a.

59. The percentage of patients attending general practitioners
who are, in fact, psychiatric cases have been variously
estimated to be from 10% to 50% of all cases (5). Shepherd et
al (6) have derived a figure of 38% from a study carried on in
London, England.

## 60. Indirect Costs

a)	Undeclared mental illness	\$ 150,000,000
	Total indirect cost	\$ 150,000,000 p.a.
Grai	nd total of direct and indirect costs	\$ 340,000,000

- 61. This estimate of "indirect costs" is based upon experience in

  Britain where it was found that 3% of the labour force produced
  less than it was paid. It was not found possible to reduce this
  figure to 2%. This economic drain was found not to be due to the
  physically handicapped who could often be shown to achieve higher
  than average production.
- 62. If a similar situation obtained in Canada then, since Canada's employed labour force is 6 million, with an income of 20 billion dollars a year, a 3% loss would amount to 600 million dollars.

If only one-quarter of this were due to psychiatric disablement, (and this obviously is a very conservative estimate) then the bill due to undeclared mental illness would amount to the figure of \$150,000,000 p.a.

- This total expenditure of about \$340,000,000 a year on psychiatric illness may be compared, for example, with the analagous figures for England and Wales. Abel-Smith and Titmuss (4) have estimated that the direct costs of psychiatric care amount to between 1.6% to 1.9% of the gross national product. If a similar percentage of Canada's gross national product were to be spent on mental health there would be involved a sum of between \$575,000,000 and \$685,000,000 a year, figures which overshadow by a fair margin the present estimated expenditure of \$340,000,000.
- 64. At the same time, however, it must be noted that large direct costs are already producing evident benefits in Britain. Tooth and Brooks (7) have pointed to well-developed trends in mental health care which already are producing large indirect benefits. Thus, by 1975 in Britain there is likely to be a need for only 340 short-stay beds, 530 medium-stay and 890 long-stay beds per 1,000,000 of the population. This means that there will be required about 180 beds per 100,000 population in contrast to the existing 340 per 100,000. Over the next 15 years, then, there will be a reduction of almost 50% or an elimination of 70,000 hospital beds. The accompanying increase in the earning capacity of these discharged patients should not be insignificant. In the light of Tooth and Brooke's analysis (7) the fact that there are already 380 mental institution beds per 100,000 population in the province of Ontario reinforces the

suggestions that what is required in Canada are new methods and new means of organizing our resources rather than the establishment of more hospital beds. Indeed the very success of the English scheme depends in large part on the community resources we are advocating.

- 65. It has been said that the cost of health is not a part of national expenditure which lends itself easily to statistical treatment.

  In the widest sense all expenditure (even for food and clothing) which contributes to the maintenance of health and the prevention and cure of diseases must be called into account.

  Within limits each country decides what its own sickness rate is to be by the ways in which it allocates its resources and orders its affairs.
- 66. The challenge is clear.

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SECTION ON PSYCHIATRY - Ontario Medical Association Appendices 1 to 12 - supporting documents to Appendix #16, not included in the original printing

## 68. Hospital Facilities for Psychiatric Treatment in Ontario (prepared

by Dr. C. A. Buck) - (Appendix 1)

- 1. Scope of Hospital facilities: Provincially Directed -
  - 13 general purpose mental hospitals

    5 hospitals for mentally retarded

    1 hospital for epilepsy and mentally ill
    with tuberculosis

    1 hospital for emotionally disturbed
    children

    2 2,985 beds
    plus 1,165 patients
    in approved Homes.
  - general hospital psychiatric units 531 beds in 17 hospitals.
  - private hospitals:

Homewood Sanitarium	250 beds
Bethesda Home for the Mentally III	80 beds
Scott Institute Psychotherapy, Kingsto	on 14 beds
Dalmeny Private Hospital, Toronto	33 beds
Stein Private Hospital, Toronto	12 beds
Bell Clinic, Willowdale (Alcoholic)	9 beds
Sunbeam Home, Kitchener (Mentally	
retarded children)	50 beds
Velleman Home, Plainfield (Mentally	
retarded children)	52 beds

#### - day care facilities:

Ontario Hospital, New Toronto Ontario Hospital, Cobourg Toronto Psychiatric Hospital

#### 69. 2. Statistics:-

a)	Number of patients	23, 150
	Number of first admissions	_
	Ontario Hospitals	5,350
	Toronto Psychiatric	303
	Psychiatric units in public	
	hospitals	3,047

	Readillissions =		
	Ontario Hospitals	3,	,003
	Toronto Psychiatr	ic	109
	Psychiatric units		
	hospitals	-	391
	1100 p 11010	٠,	,001
	Number of patients	discharged -	
	Ontario Hospitals		317
	Toronto Psychiatr		418
	Psychiatric units		410
	hospitals	•	905
	nospitais	4,	387
b)	Number and type of Medical	personnel -	
	Certified psychiatr	rists	72
	Physicians in train	ning (4 vears)	90
	General physicians	- , ,	15
	1 3		
	Psychologists		
	Qualified clinical	svehologists	55
	, ,	-7 8-2-2	
	Social Workers		
	Qualified social wo	rkers	51
	Others		24
	Occupational Therap	ists	
	Qualified occupation		s 38
	O. T. assistants	THE VIOLUPIDO	140
			110
	Nurses		
	Registered nurses		637
	Other nurses		221
	Nurses aides		432
	rarbob araob	۷,۰	102
	Attendants	9 1	549
	***************************************	۷, ۹	5-10
	Other staff	3, 8	530
		0,	
c)	Facilities for Rehabi	litation -	
-/	Boarding Homes -		mes 255
		number of par	
		number of pa	1, 100

Readmissions -

70.

71.

After Care Facilities in Hospitals -14 of the mental hospitals operate a full scale outpatient department which in most instances do follow up on patients discharged from hospital in co-operation with the in-patient staff.

72. Adequacy of Hospital Facilities -The actual ratio of patients to total bed capacity cannot be stated in a meaningful way. Over-crowding at the present time is minimal in most hospitals. Overcrowding does exist in the following hospitals:

Ontario Hospital, Aurora Ontario Hospital, London Ontario Hospital, North Bay Ontario Hospital School, Orillia Ontario Hospital, Penetanguishene Ontario Hospital, Toronto

#### 73. Quality of Physical Facilities:

Good to excellent in most hospitals but poor in the following where plans are under way for renovation and reconstruction:-

Ontario Hospitals in Aurora, Cobourg, London, New Toronto, Penetanguishene, and the Toronto Psychiatric Hospital.

#### 74. Size and Architectural Design:

The design is generally good except in the hospitals listed above where plans for the reconstruction are under way. The size varies from specialized hospitals such as Thistletown Hospital for emotionally disturbed children with 75 beds, to the Ontario Hospital School, Orillia, with 2,500 beds.

#### 75. Location:-

Several hospitals situated a few miles outside of a town or city are felt to be poor locations. Eastern Ontario, Western Ontario and the area served by the Ontario Hospital, Port Arthur, have adequate beds to serve the area. Central Ontario, including mainly Metropolitan Toronto and the horseshoe area around the head of Lake Ontario, has a considerable shortage of beds. A shortage also exists in the area served by the hospital at North Bay.

#### 76. Adequacy of Staff: -

Numerically adequate except in professional categories, namely psychiatrists, social workers, psychologists, occupational therapists.

## 77. Salary Scales:-

Reasonable in most categories but totally inadequate in some of the professional categories such as psychiatrists, psychologists, social workers, nurses.

### 78. Psychiatric Outpatient Services in Ontario (prepared by Dr. H. W.

Henderson) - (Appendix #2)

This report deals with psychiatric outpatient services, exclusive of the private practice of psychiatry available to residents of the Province of Ontario in the year 1960.

- 79. Part one of this report is devoted to statistical data relating to:
  - a) Number of facilities
  - b) Number of professional staff
  - c) Case loads
  - d) Sources of referrals
  - e) Location and distribution of services.
- 80. Part two of the report provides brief comment on:
  - f) Adequacy of services
  - g) Integration of services
- 81. There are four types of facilities represented:
  - 1. Provincial Services identified by -
    - a) service established and maintained under administrative authority of the Mental Health Branch of the Provincial Department of Health.
    - b) service operated on full time basis (10 half days per week)
    - assistance provided by clinical team working under direction and supervision of a qualified psychiatrist
    - d) majority of staff employed on salaried basis
    - e) assistance provided without charge.
- 82. 2. General Hospital Services identified by -
  - a) service established and maintained under administrative authority of a public general hospital
  - b) with five exceptions, services offered on a part time basis
  - with exception of five full time services, assistance provided by psychiatrist primarily enjoyed in private practice, usually without assistance of psychologist or social worker
  - d) while there is no fee for service, eligibility may be determined by a means test or restricted by residence requirements, and a registration fee may be charged.

- 83. 3. Community Services identified by
  - a) service established and maintained under administrative authority of Municipal Department of Health
  - b) service operated on a full time basis
  - assistance provided by clinical team working under direction and supervision of a psychiatrist
  - d) all staff employed on a salaried basis
  - assistance provided without charge to residents of a defined area.
- 84. 4. Other Services not fulfilling criteria for above categories and identified by -
  - service provided by clinical team under direction and supervision of qualified psychiatrist
  - b) service operated on a full time basis
  - c) majority of professional staff are employed on salaried basis
  - d) service provided without charge or for minimal fee based on means test.

#### 85. PART I

#### A. NUMBER OF OUTPATIENT FACILITIES

1. Provincial Services - In 1960, there were 25 provincial outpatient services in operation. Twenty of these facilities functioned as "general purpose" mental health clinics, offering diagnostic and treatment services to individuals, and consultation services to health, educational and welfare agencies, and the courts. Seven of the twenty facilities maintained a regular schedule of travelling clinic services to nineteen population centres in a area served by the clinic; four offer day care. Five of the twenty facilities are specialized in function, three serving children exclusively, one serving adults only, and one serving the courts in the Metropolitan Toronto area.

- 86.

  2. General Hospital Services Most large general hospitals in the province now have psychiatrists on the attending and consulting staff who provide some assistance to outpatients. In most instances, the assistance consists of a psychiatric consultation for patients attending the emergency or other outpatient department of the hospital. With the increasing demand for such assistance, the psychiatrists usually arrange to be available for specified hours each week. In addition to these part time services, five general hospitals have established full time services, employing professional staff on a salaried basis, with assistance from a National Health Grant.
- 87. 3. Community Services In 1960, there were three facilities operated by Municipal Health.Departments which satisfied the criteria stated for community services. Two of these facilities serve children only.
- 88.

  4. Other Services There are five facilities which satisfy the criteria of other services. Two are operated by a non-medical agency and administered by a lay board. Each charges a fee which is much less than the cost of the service provided and determined in accordance with the means of the patient. The other three facilities, established and maintained by a municipal Board of Education, a Juvenile and Family Court, and a Provincial Research Foundation, provide assistance without charge.

#### 89. B. NUMBER OF PERSONNEL

 <u>Provincial Services</u> - The following professional staff were employed in the twenty-five provincial services:

	Full Time	Part Time
Psychiatrists	53 *	34 (8 full time)
Psychologists	33	13 (6 full time)
Social Workers	34	13 (6 full time)
Other (nurses, O.T.	,	
Speech Therapists,		
etc.)	31	

<sup>\* -</sup> including 15 post graduate trainees.

90. 2. General Hospital Services - Most psychiatrists engaged in private practice hold a hospital appointment and provide some assistance to public out-patients. Information regarding the number of psychiatrists providing such assistance, or the amount of time given to such a service is not readily available.

In general, the services of a psychologist or a psychiatric social worker are not available to patients attending part time out-patient service in a general hospital. The five general hospitals that maintain full time psychiatric outpatient services employed the following professional staff:

	Full Time	Part Time
Psychiatrists	4	8
Psychologists	6	3
Social Workers	6	2

91. 3. Community Services - The three services operated by

Municipal Health Boards employed the following professional Staff:

	Full Time	Part Time
Psychiatrists	3	0
Psychologists	9	0
Social Workers	3	1
Other (Public Heal	lth	
Nurse)	4	0

 Other Services: - The professional staff employed in the five services included in this category is as follows:

	Full Time	Part Time
Psychiatrists	10 *	14 **
Psychologists	22	11
Social Workers	13	4
Other (Nurse, O. 7	Γ.,	
Teacher)	3	8

<sup>\* -</sup> includes 2 post graduate trainees

## 93. C. CASE LOADS

All provincial outpatient services adopted a standard procedure for reporting statistical data in 1957. Since that time many of the full time services operating under other auspices have adopted this procedure. The detailed information contained in this section is derived from the reports submitted to the Division of Medical Statistics of the Provincial Department of Health.

94.

1. Provincial Services - The total number of patients attending the twenty-five provincial outpatient services in 1960 was 16,802.

Of this number 5,830 (34.7%) were children under age 17. This case load can be further broken down as follows:

Active cases from 1959 -	4,800
Children 1,140 (23.7%) Adults 3,666	
New Admissions -	9,676
Children 4,040 (41.8%) Adults 5,636	
Readmissions -	2,320
Children 650 (28%) Adults 1,670	

95. The total number of interviews conducted by all staff is

106,296. The average number of interviews per patient seen

<sup>\*\* -</sup> includes 8 post graduate trainees

at the "general purpose" mental health clinics during the past four years is 5.2, and for the specialized services 11.6.

Because of the varied pattern of services and limited experience at day care centres, the average number of interviews with professional staff per patient attending this type of facility is not established.

- 2. General Hospital Services The total number of patients seen at the five general hospitals operating full time outpatient services is 1,454. Three of the hospitals maintain outpatient services specifically for children and accounted for 830 patients out of the total case load. The total number of interviews conducted is 12,188.
- by municipal Health Departments provided assistance to 1,852

  patients of which 1,806 were children under 17. The total

  number of interviews conducted by the staff of these three

  services is 8,731. Two of these facilities have an average

  number of interviews per patient of 3.0 and 4.3 suggesting that

  the service rendered is primarily diagnostic or consultative.

  The third service would appear to offer a treatment service to

  most children seen, granting an average of 15 interviews.
- 98. 4. Other Services Statistical data relating to case loads could only be obtained for four of the five services included in this category. These four services provided assistance to 7,019 patients, and conducted 22,402 interviews. The nature of the

services rendered varied a great deal from one facility to another as did the average number of interviews per patient seen (range 2.0 to 88.0)

#### 99. D. SOURCES OF REFERRAL

The following breakdown of referral sources is taken from the Provincial Statistical Reporting Tables:

- 1) Welfare Agencies, including Relief Agency
  Family Agency
  Children's Agency
  Governmental Agency
  Other Welfare Agency
- 2) Health Agencies, including Family Physician
  Other Health Agency (except school health
  service)
- 3) Educational Agencies, including Health Services
- 4) Courts, Probation Officers, Police
- 5) Friends and Relatives
- 6) Self or Parent
- 7) Other

While the breakdown of new admissions according to referral source varies considerably among facilities offering different types of services, and even among facilities providing similar services, some generalizations are possible.

1. Provincial Services - Approximately 50% of the patients attending the provincial services are referred by health agencies.

Within this category of referral source, 75% are referred by family physicians. Of the patients attending the "general purpose" clinics, the welfare agencies and educational agencies each contribute 10 to 15% of the case load. Within the category of welfare agencies, children's agencies account for more than 50% of the referrals. Self referrals may represent as much as 30% of

the case load, but in most instances account for less than 15%.

The number of court referrals varies, but in general accounts for 8 to 10% of the case load.

- 2. General Hospital Services Detailed information regarding sources of referral is not available for services included in this category. It would appear, however, that adults are generally referred from another outpatient service within the hospital.

  The hospitals which provide full time outpatient services for children receive a high percentage of referrals from family doctors.
- 3. Community Services Detailed information regarding source of referral is available for the two facilities included in this category which serve children exclusively. The one received 75% of the referrals from educational agencies, whereas the other receives approximately 25% of referrals from this source and about the same proportion from welfare agencies and health agencies.
- 4. Other Services Information concerning referral sources is available for one of the facilities included in this category. The service provided is comparable to a "general purpose" mental health clinic and self referrals, plus referrals by parent or relative account for nearly 50% of the new cases seen.

  Approximately 25% of new cases referred by health agencies with the referrals from family physicians account for 75% of this group. Fifteen percent of new cases are referred by welfare agencies, with children's agencies contributing half of these referrals.

#### 104. E. LOCATION AND DISTRIBUTION OF SERVICES

Eastern Region - Counties of Frontenac, Renfrew, Leeds,

Lanark, Stormont, Dundas, Glengarry, Carleton, Prescott,

Russell.

Popula	tion	763,000
Popula	tion centres over 10,000 -	
a)	Ottawa and vicinity	300,000
b)	Kingston	48,000
c)	Cornwall	43,500
d)	Brockville	17,000
e)	Pembroke	16,000

Full time services at Ottawa, Kingston and Brockville.

Travelling clinic service to Cornwall and Pembroke.

105. 2. Lake Ontario Region - Counties of Lennox and Addington,

Hastings, Prince Edward, Northumberland and Durham,

Peterborough, Victoria, Haliburton.

Population	338,000
Population centres over 10,000 -	
a) Peterborough	46,500
b) Belleville	29,000
c) Trenton	12,500
d) Lindsay	11 000

Full time services at Peterborough and Cobourg.

Travelling Clinic service to Belleville.

106. 3. Metropolitan Region - Counties of Ontario, York, Peel, Halton.

> Population 2,062,000

Population centres over 10,000 -

a) Metropolitan Toronto and vicinity including Pickering Township, Markham Township, Vaughan Township and Toronto Township 1,620,000 b) Oshawa 60 000

~,	ODINGTIC	00,000
c)	Burlington	44,500
d)	Trafalgar Township	30,000
e)	Brampton	17,000
f)	Richmond Hill	16,000

g)	Whitby	12,000
h)	Georgetown	10,000
i)	Oakville	10,000

Full time services in Metropolitan Toronto and at Whitby.

Travelling clinic services to Burlington and Milton.

## 107. 4. Niagara Region - Counties of Wentworth, Lincoln, Welland,

Haldimand and Brant.

Popula	tion	794,000
Popula	tion centres over 10,000 -	
a)	Hamilton	261,000
b)	St. Catharines	85,000
c)	Brantford	53,500
d)	Welland	36,000
e)	Stamford Township	29,500
f)	Niagara Falls	22,500
g)	Port Colborne	15,000

Full time services at Hamilton and St. Catharines.

Travelling clinic service to Brantford and Dunnville.

# 108. 5. <u>Lake Erie Region</u> - Counties of Norfolk, Elgin, Oxford and

Middlesex.

Population	403,000
Population centres over 10,000 -	
a) London	158,000
b) St. Thomas	22,500
c) Woodstock	20,000

Full time services at London, St. Thomas and Woodstock.

Travelling clinic at Simcoe.

# 109. 6. Lake St. Clair Region - Counties of Lambton, Kent and Essex.

Popula	tion	478,000
Popula	tion centres over 10,000 -	
a)	Windsor and vicinity	187,000
b)	Sarnia	49,000
c)	Chatham	29,000

Full time services at Windsor and Sarnia.

Travelling clinic service to Chatham.

#### 110. 7. Upper Grand River Region - Counties of Huron, Perth,

Waterloo, Wellington.

Popula	tion	367,000
Populat	tion centres over 10,000 -	
a)	'Kitchener	73,000
b)	Guelph	39,000
c)	Galt	27,000
d)	Waterloo	20,500
e)	Stratford	20,500
f)	Preston	11,500

Full time services at Kitchener.

Travelling clinic services to Guelph, Fergus.

### 111. 8. Georgian Bay Region - Counties of Bruce, Grey, Dufferin,

Districts of Muskoka and Parry Sound.

Popula	tion	320,000
Popula	tion centres over 10,000 -	
a)	Barrie	22,000
b)	Owen Sound	17,500
c)	Orillia	14,500

No full time services in region.

Travelling clinic service to Owen Sound.

### 112. 9. Northeastern Region - Districts of Nipissing, Sudbury, Algoma,

Cochrane and Temiskaming.

Population	497,000
Population centres over 10,000 -	
a) Sudbury	77,500
b) Sault Ste. Marie and distri-	et 53,000
c) Timmins	28,500
d) North Bay	23,000
e) Teck Township	17,500
f) Elliott Lake	15, 500

Full time service at North Bay.

227,000

Lakehead Region - Districts of Thunder Bay, Rainy River,
 Kenora and Patricia.

Population centres over 10,000 -	
a) Fort William	43,968
b) Port Arthur	44,581
77	10 401

Full time service at Port Arthur.

Travelling clinic service to Fort William, Kenora, Dryden,
Atikokan, Fort Frances.

## 114. <u>PART II</u>

#### F. ADEQUACY OF SERVICES

Population

The thirty-eight full time services which were operative in 1960 provided approximately 60 clinic teams. Taking the population as six million, full time psychiatric outpatient services were available in the ratio of one clinic team per 100,000 population. These figures do not include the part time services rendered by psychiatrists in outpatient departments of general hospitals.

- 115. Two thirds of the total number of facilities and two thirds of the total number of clinical teams were provided by the Provincial Department of Health.
- 116. Services are not evenly distributed throughout the province. In the Metropolitan Toronto area, available service exceeds the ratio of one clinic team per 50,000 population, with most of the facilities being concentrated in the centre of the city. The total number of clinical teams are about equally divided between provincial and non-provincial services. The 542,000 people living in the Metropolitan Region and outside Metropolitan Toronto are served by one clinic team.

- 117. Similarly, the services in Ottawa and London approximate one clinic team per 50,000 population. In the two remaining cities with populations in excess of 100,000, Hamilton and Windsor, the ratio is approximately one clinic team for 150,000.
- 118. In general, the distribution of services conforms to the distribution of population being concentrated in the southern portions of the province. In the three northern regions, which represent vast territories, services are reduced to one clinic team for 250,000 to 500,000.

#### 119. G. INTEGRATION OF SERVICES

Ten of the twenty-five provincial services are located at Ontario Hospitals, with one exception all the provincial services are administratively tied to a mental hospital.

- 120. Within the local community the full time psychiatric outpatient service is now accepted as an integral component of the health services. These facilities restrict their clinical services to the practice of psychiatry, and rely on the family physician to provide any necessary attention for physical disorders. None of the clinics make home visits.
- 121. Forensic Psychiatry in Ontario (prepared by Dr. K. G. Gray) (Appendix #3)

The operation of forensic psychiatric services in Ontario has established that a proportion of the people on trial in criminal courts and a proportion of the people who are sentenced in courts are suffering from mental and neurotic illness. It has also been established that a proportion of these people will benefit from

psychiatric treatment and that in some cases treatment may be utilized as an alternative to imprisonment. At the present time no one is in a position to say what this proportion may be.

- 122. Following is a statement of the psychiatric facilities which have proved useful. Where there is sufficient concentration of population, as in Metropolitan Toronto, it is feasible to establish these as specialized clinics and hospital services dealing only with offenders. In areas where the population is less concentrated, it might be found more economical for a clinic or hospital to incorporate some services in forensic psychiatry without establishing separate specialized forensic services.
- 123. Juvenile Offenders An outpatient service is required to assess the mental health of juvenile offenders and to provide outpatient treatment when required. It is also necessary to have available an in-patient service for juvenile offenders who need to be in custody during the mental health assessment and for the hospital treatment of those offenders requiring such treatment. Psychiatric facilities are required for certain cases who are in training schools.
- Adult Offenders An outpatient clinic is required for the assessment of offenders who are not in custody and who are referred by the courts.

  The clinic should also be able to provide treatment for offenders who will benefit from such treatment and who are not in custody.

  Similarly, an in-patient service is required for the adult courts for assessment and treatment. Psychiatric facilities should also be available for the correctional institutions, namely, the prisons, reformatories, industrial farms and training centres.

- cases will be discovered which are not well suited for either mental hospital or correctional institution. These are cases in which the primary problem is one of antisocial conduct with an underlying neurotic basis. These people are not obviously mentally ill and would not be considered suitable for treatment in a mental hospital.

  On the other hand, they are unlikely to be able to receive the requisite intensity of psychiatric treatment in reformatory or training school. Consideration should be given to the establishment of a special institution for such cases. An illustration is to be found in the special institution known as Grendon Underwood which is now being built in England as a psychiatric prison hospital (see International Review of Criminal Policy, October 1961, page 10.)

  Similar institutions in Holland and Denmark have been described.
- Research A description of the researches being carried on in forensic psychiatry in the department of psychiatry, of the

  University of Toronto and the Toronto Psychiatric Hospital have been incorporated into the research report compiled, by Dr. J. W. Lovett Doust (Appendix #8). In this report it may be noted that there are

  17 research projects proceeding at the present time.
- 127. <u>Appendices</u> Appended are some tables illustrative of the present situation in Ontario.
- 128. Acknowledgements The information in this report has been compiled by the forensic service of the Toronto Psychiatric Hospital. The assistance of the Deputy Minister of Reform Institutions, Mr. J. A. Graham, is acknowledged.

#### Information Regarding Correctional Institutions in Ontario 129.

The number of individuals in all types of correctional a)

institutions in Ontario as of March 31, 1961:

Reformatories, Industrial Farms and Training Centres 3,411 1.240 Ontario Training Schools City, County and District Jails 1,975 6,626

Below is the breakdown of prisoners in City, County and

District Jails:

On Remand	434
Awaiting Trial	93
Serving Unexpired Sentences	1,448
-	1,975

Professional personnel attached to correctional institutions in 130. b)

#### Ontario:

	Full-time	Part-time	Consultants
Occupational Therapist	s 3	_	-
Social Workers	9	1	1
Psychologists	14	3	1
Psychiatrists	1	12	-

- c) For the year ending March 31, 1961: 131.
  - 504 adult male inmates received outpatient consultation at the Neuropsychiatric Clinic in Guelph.
    - 77 received in-patient care.
    - 18 were transferred to mental hospitals.

#### Admissions and Disposals, Don Jail, Toronto 1961 132.

	Male	Female	Total
Persons suspected of being men ill and apprehended under the	tally		
Mental Hospitals Act, Section			500
#28:- Transferred to Ontario	159	50	209
Hospital:-	109	36	145
Discharged:-	50	14	64

#### Admissions and Disposals, Forensic In-Patient Service, Toronto 133.

#### Psychiatric Hospital - 1958, 1959, 1960

	1958		1959		19	<u>60</u>	
	<u>M</u> <u>F</u>	Total	<u>M</u> <u>F</u>	Total	M	<u>F</u> '	Total
Admitted under section 9 (1) (e) of the Psychiatric							
Hospitals Act:- Transferred to Ontario	69 20	89	62 18	80	64	17	81
Hospital:- Discharged to court	18 16	34	13 13	26	15	11	26
or home:-	46 7	53	49 5	54	52	5	57

#### New Cases by Referring Agency (Courts, Probation Officers, Police) 134.

Medical Statistics Branch, Ontario Department of Health, November 15, 1961:-

	1958		1959		1960	
	Under	17 &	Under	17 &	Under	17 &
	16	over	16 .	over	16	over
Brockville, O. H.	13	42	6	29	18	22
Cobourg Day Care	-	-	-	-	-	-
East York-Leaside	1	-	-	-	3	-
Hamilton, O. H.	23	18	11	9	13	10
Hamilton City Mental						
Health Clinic	22	21	26	_	36	-
Kingston, O. H.	13	47	13	35	17	47
Kitchener General	10	53	12	37	12	52
London, O. H.	15	14	13	14	11	6
C. P. R. I. London	***	-	-	-	-	1
Victoria Hospital London	1 1	26	5	36	2	36
New Toronto, O. H.	-	-	-		3	4
North Bay, O. H.		-	-	_	8	7
Ottawa Civic Hospital	31	27	23	18	24	15
Ottawa General		ata .	1	7	7	-
Owen Sound Mental Health						
Clinic	-	-	1	1	3	7
Peterborough Civic	1	17	3	14	-	21
Port Arthur, O. H.	15	22	16	18	21	46
St. Catharines General	27	72	19	45	11	33
St. Thomas, O. H.	20	32	22	25	26	42
Sarnia Mental Health	-	-	-	-	6	7
Toronto Mental Health						
Clinic	-	2	-	-	-	2
Toronto, O.H. (O.P.D.)	-	2	-	17	1	3
Thistletown, O.P.D.	3	-	-	-	-	-
Toronto Psychiatric,						
Children's Unit	-	-	3	and a	6	-

	1958		1959		1960	
	Under 16	17 & over	Under 16	17 & over	Under 16	17 & over
Toronto Psychiatric,						
Forensic Clinic -	17	85	17	116	12	121
Toronto Psychiatric,						
Day Care Centre -	-	-	-	-	~	-
Toronto Psychiatric,						
O.P.D	-	~	-	2	-	11
Whitby O. H	-	-	-	-	2	-
Windsor Mental Health-		-	10	15	22	27
Woodstock, O.H	-	_	-	-	2	3
York Twp. Child						
Guidance Clinic -	2	1	2		2	_
TOTAL:	214	481	203	438	268	523

# 135. Persons Admitted to Ontario Hospitals under Section 38 of the Mental

# Hospitals Act

	19	957		19	58		19	59	
Ontario Hospital	M	F	Total	. <u>M</u>	F	Total	<u>M</u>	F	Total
Aurora	1	0	1	0	0	0	0	0	0
Brockville	10	1	11	13	0	13	15	0	15
Cobourg	0	4	4	0	0	0	0	0	0
Hamilton	93	24	117	72	19	91	37	9	46
Kingston	37	7	44	31	8	39	29	8	37
London	33	3	36	10	3	13	6	0	6
New Toronto	58	11	69	74	14	88	22	9	31
North Bay	11	1	12	26	8	34	19	0	19
Orillia	0	0	0	0	0	0	0	0	0
Penetanguishene	4	3	7	3	0	3	2	0	2
Port Arthur	47	9	56	. 80	15	95	61	6	67
St. Thomas	79	19	98	33	5	38	10	1	11
Smiths Falls	0	0	0	0	0	0	0	0	0
Toronto	83	51	134	31	20	51	10	2	12
Whitby	64	9	73	58	8	66	26	3	29
Woodstock	1	0	1	1	0	1	0	0	0
TOTAL:	521	142	663	432	100	532	237	38	275

136. Disposal of Persons Admitted to Ontario Hospitals Under Section 38 of the Mental Hospitals Act

	1957	7_		19	958		<u>19</u>	59	
	<u>M</u>	F	Total	<u>M</u>	F	Total	M	F	Total
Certified	166 7	75	241	165	52	217	113	20	133
Discharged	349	35	414	267	48	315	124	18	142
No Disposal	6	2	8	-	-	-	-	-	-
TOTAL:	521 14	12	663	432	100	532	237	38	275

# 137. Report on Outpatient Psychiatric Facilities for Children in Ontario (prepared by Dr. A. Hood) - (Appendix 4) Present Situation

- a) <u>Case Load</u> In 1960, between 10,000 and 11,000 children, 16 and under were seen for diagnosis and treatment in psychiatric outpatient clinics. A few adolescent patients in this group were also treated in day centres. The number of boys attending these clinics is almost twice as great as the number of girls. The majority of patients are of public school age.
- 138. A review of the experience of existing clinics in 1961 indicates that the number of children attending them will be even higher than in 1960. These increases are real since there were no additional psychiatric facilities for children created until very late in the year.
- b) Type and Location of Clinics There are twenty-nine clinics which see some child patients. Two of these clinics were opened in the late
   Fall of 1961 and have not yet completed their basic professional staff

requirements. They were located at Newmarket and Oshawa. Of these twenty-nine clinics, only seven concern themselves exclusively with children. The remainder offer psychiatric services for adult patients as well. It would appear that this is the most likely continuing trend in the development of new clinics in this province, i.e., that they will have services for both adults and children.

140. There is no single pattern by which clinics for children are established.

A breakdown of the twenty-nine clinics shows the following affiliation and sponsorship:

Types and Locations of Clinics:

Attached to existing mental hospitals	12
Attached to general hospitals	7
Attached to local health departments	6
Attached to Board of Education	1
Community based clinics	3

- 141. Certainly the vast majority of all clinics have been created, financed and supported by the Department of Health, Province of Ontario.

  There has been considerable assistance in this undertaking from the Federal Health Grant scheme and to a lesser extent from municipal funds.
- 142. All the clinics are totally tax supported and hence are free to patients
  with one exception. A community clinic in Toronto is largely
  supported by private funds from the United Appeal and does charge
  fees on a sliding scale to its patients according to their ability to pay.
- 143. Seven of the clinics seeing children are located within Metropolitan

  Toronto. It is also within Metropolitan Toronto that six of the seven

  clinics in the province which see children only are located. The

  remaining such facility is in Ottawa.

144. c) <u>Personnel</u> - At the present time, on the basis of the clinics reporting, there would appear to be the following breakdown of staff;

Psychiatrists	40
Social Workers	34
Psychologists	37
Others	5

About 70% of these staffs are full-time in the clinics.

- in the numbers of trained personnel working in these clinics in 1961 compared with 1960. One clinic may have gained the services of a full or part time psychiatrist, social worker, psychologist, speech therapist, etc., while others have lost similar personnel. All clinics report the need for additional staff, in particular for psychiatrists with specialized training in child psychiatry. No clinic outside Toronto presently has such a person on staff although some psychiatrists by force of circumstances have gained much valuable on-the-job experience through seeing children over the years.
- 146. The results of a questionnaire asking clinics what they felt was presently required in terms of additional staff within their own setting, revealed the following:

Trained Child Psychiatrists	12
Social Workers	13
Psychologists	9
Teachers	2
Speech Therapists and	
Remedial Personnel	5

These figures would undoubtedly be somewhat increased by the needs of the clinics which did not answer the questionnaire.

147. At present in clinics with a mixed case load of children and adults

the psychiatrists report that they spend anywhere from 10% to 75% of
their time seeing children. It would appear that it is in the newest

clinics that the least time is being spent with children. On the whole, the social workers and psychologists in these clinics devote more time to seeing children and their families than do the psychiatrists.

- training course in Child Psychiatry In July 1960, the first two-year training course in Child Psychiatry in Ontario was initiated by the Department of Psychiatry, University of Toronto. At present, two clinics in Toronto are engaged through this program in the direct training of these psychiatrists in outpatient work. Psychiatrists from the other university approved settings in the community contribute through didactic and seminar teaching. At present it has been possible to accommodate three persons in the first year and three in the second year of this course. The first "graduates" will be finished in June 1962.
- 149. For some years, the two-year course in General Psychiatry at the

  University of Toronto has included six months of varying amounts of

  direct work with children in two or three of the settings in the community.

  More recently, such postgraduate courses in Psychiatry have been

  initiated by the University of Western Ontario and Queen's University.

  Similarly, in these settings some degree of exposure to the psychiatric

  problems of children is afforded. Thus every psychiatrist who

  successfully completes his training in Ontario has had some experience

  in working with children, but it is experience below the level which

  would be felt appropriate for qualification as a Child Psychiatrist.
- 150. It is clear from the needs being expressed by the clinics in terms of their present situation and also in terms of the additional facilities which they would like to see developed in their areas, both of an out-

patient and in-patient nature, that a considerable number of trained child psychiatrists are presently required and will be required in the future.

- 151. We see too, the need for additional ancillary personnel in these same terms, both in relation to existing and projected facilities. Social workers with training in psychiatric settings and psychologists with a background in clinical psychology and internships in psychiatric institutions are clearly going to be needed in greater numbers if facilities are to be adequately staffed.
- e) Private Practice One feels that the impact of private practice on the emotional problems of children requiring treatment is not very significant. Compared with the numbers of psychiatrists who engage in private practice those who will accept child patients is rather small.

  We have referred before to the rather small number of fully trained child psychiatrists in Ontario. Only a few of these engage in any private practice whatsoever, and one is led to the conclusion that the number of children who are treated by this means are very few indeed. This is not only because of the small numbers of psychiatrists but the relatively high cost of psychiatric fees when both children and their parents will be in need of the psychiatrist's time.

#### 153. Unmet and Future Needs

a) Outpatient Facilities - Practically all the clinics reporting indicated what they felt to be the need for additional outpatient facilities in areas somewhat removed from their own location but which they presently must attempt to serve. Six of the present clinics are also functioning as

travelling clinics. At regular intervals they move into surrounding communities for a day at a time and offer a diagnostic and consultative service to the medical practitioners and social agencies in the area. Both from an indication of where patients are coming from and by the experience of the demands on the travelling clinics there is a real indication that expanding outpatient facilities in larger communities or county units are desirable.

- 154. It is obvious that some of our outpatient services are expected to cover large areas involving several counties. Because of this lack of accessibility, the usefulness of existing clinics to families is limited.

  The almost universal recommendation in these instances was to locate clinics in other cities in their district not presently served by their own facilities. Examples of this were such centres as Belleville, Guelph, Chatham, etc.
- 155. In most instances it was felt that these clinics should be attached to local general hospitals or be administered by the local health authority (municipal department of health.) The provision of consultative services to the schools by such clinics was almost continuously stressed in the reports of the clinic directors.
- 156. In the larger cities such as Toronto, Hamilton, clinics to serve the growing suburban population was emphasized, e.g., Burlington,

  North York, Scarborough. The principle of decentralization in the positioning of clinics strategically in relation to those whom they would serve was clearly enunciated in our survey. Furthermore, the need for this to be related to other community health and welfare services

was also stressed. Both the need for additional diagnostic facilities and additional family support would seem to underline the feeling for this kind of co-ordination.

- 157. Perhaps one word of caution may be voiced. A mental health clinic serving children cannot be all things to a community. It is no substitute for a poor school system, inadequate child care and protection services, recreational facilities and juvenile courts, or for public welfare and family counselling services. A clinic has a specific job to perform and should not be put into a community on a deficit basis. It runs the risk of being asked to do more things than it is really able to do and if it fails to carry out the expectations of the community, no matter how unrealistic, it may fail to get the co-operation and support it deserves.
- 158. In totalling up the suggestions which were made by the clinics which answered the questionnaire, one comes up with the following figures:

Additional outpatient clinics devoting at least part of their time to working with children: 22

This would require the services of 22 clinic teams to staff these establishments – a clinic team consisting of a psychiatrist, social worker and psychologist.

159. Communities in which it was suggested that these be established as a result of our questionnaire are as follows:

Peterborough, Kitchener, Sault Ste. Marie, Sudbury, Timmins, Kirkland Lake, Bracebridge, Chatham, Simcoe, Guelph, Brantford, Burlington, Belleville, Pembroke, Windsor, Welland, Niagara Falls, Scarborough, North York, Brockville, York Township.

160. In some instances the suggestions were for additional clinics in areas in cities already being served but more closely related to community settings or to a school setting. However, in general, it was the consensus that these new clinics should be attached either to a general hospital or set up through the aegis of the local department of health. These suggestions represent only the thinking of the directors in the existing clinics and, of course, might not coincide in several respects with the overall view which is available to the Division of Community Mental Health Services of the Mental Health Division, Department of Health. Province of Ontario.

- 161. b) In Patient Services Almost without exception, every clinic director felt the pressing need of some kind of in patient services for children. A survey of the material indicates that these are of two kinds:
  - a small unit where diagnostic assessment and treatment could be undertaken in relation to acute psychiatric disorders in children.
  - institutions providing for longer term care and treatment of emotionally disturbed children.
- 162. In terms of the small unit, the usual suggestion was for a unit of ten to twenty beds although there was considerable variance in where these should be established, that is, in relation to a general hospital or as a residential unit separate from other hospital facilities. If one were to total the suggestions in terms of the small, short term treatment and investigation units, on the basis of those who replied to the questionnaire, we arrive at a figure of approximately 250 to 300 beds scattered throughout the province.
- 163. In terms of longer term care in institutions, the need for these seemed to be felt mainly by those who were practising in highly populated areas.
  The total of these suggestions seemed to amount to about 600 beds

- although they would wish to include a certain proportion of these beds for the care of mentally defective children close to their own homes.
- 164. What seems to really emerge is that all clinics find themselves in the position of not being able to help a certain number of highly disturbed children who come to them, through an outpatient facility. There is a feeling that intensive in-patient treatment is required, and facilities for this are sadly lacking. Children hospitalized for psychiatric disorders can not be adequately treated in existing general hospitals or mental hospital facilities. The Children's Hospital at Thistletown, Ontario, is inadequate in terms of the needs across the province both by the nature of the limited number of beds and by the restriction of admission to those who have not passed the age of eleven years, six months, at the time of admission.
- Protestant Children's Village, Ottawa, Warrendale at Newmarket,
  Sunnyside at Kingston and Maryvale in Windsor, etc., who do accept
  emotionally disturbed children. However, there are inevitably long
  waiting lists at these institutions which are in essence group living
  situations for children rather than psychiatric treatment centres.

  In relation to these institutions also there are certain age limitations
  which restrict their usefulness in relation to some of the most pressing
  disturbances in children. There is a particular absence of facilities
  for disturbed adolescents. Many of these children, because of the
  lack of appropriate facilities, may help to swell the population at our
  Provincial Training Schools, who in turn are without adequate psychiatric
  and social rehabilitation staff.

in patient services were acted upon, the number of trained psychiatrists, social workers, psychologists, occupational therapists, nurses, teachers and child care workers that would be required would amount to a considerable number indeed. In addition to the suggestions for in patient services, mention has also been made in some reports of the benefits that might be derived from the admission of children to special day care centres geared to their needs.

### 167. Conclusions

Existing outpatient facilities are not able to adequately cope with the existing and potential demand for services on the following bases:

- (i) inadequate numbers of trained staff in all disciplines
- (ii) lack of easy accessibility to children and families in trouble
- (iii) inability of training facilities to provide trained staff at the rate which expansion is required.
- 168. The general impression is that what is required is a diversification of services to meet the varying needs of children, and the specific communities in which they live and that these services should be strategically located where they will do the most good for the greatest number. There is no single answer to the problem of treating emotionally disturbed children. Outpatient clinics, day care centres, short and long term institutional placement, psychiatric services in the schools and in the courts and correctional institutions are all required. These services must not only be co-ordinated in local areas in relation to each other but in relation to the total health and welfare structure of the area.

169. Assessment of Psychiatric Facilities for Geriatric Population of

Ontario (prepared by Dr. M. E. Miller) (Appendix #5)

Introduction

The following data are gleaned from a variety of sources, both private and governmental, and thus presents a certain unevenness regarding the total Ontario situation. This fact is of significance and its corollary obvious. That is, a central department within the Department of Mental Health which monitors geriatric problems throughout the province would provide a needed impetus for a more thoroughgoing consideration of the bio-psycho-social problems of older people. The concept of geriatric psychiatry as well needs better definition. Its restriction to the consideration of "chronic brain syndrome - senile in type" limits unnecessarily the necessity for studying this particular life epoch of the individual and group in all its specialized aspects.

#### 170. Material

To be considered are:

- 1. Population statistics.
- Provincial and community facilities re housing and care of the aged.
- Similar facilities provided by churches, organizations, ethnic groups.
- 4. Ontario Hospital data.
- 5. Community psychiatric facilities re the aged.
- 6. A philosophy of facilities and principles of care re the aged.
- 171. 1) Population Statistics The present and projected statistics are as follows. The projections do not take account of immigration figures. (approx. 600/year.)

172. Population Projections of the Population of Ontario aged 65 and over

(Department of Economics, Government of Ontario, November 24, 1961)

Year	Sex	65-69		75-79	80 & over	Total Group 65 & over
1960	Male Female Total	91.5	65.5 75.9 141.4	43.3 53.7 97.0		222.4 265.1 487.5
1965	Male	86.6	62.0	40.8	29.8	219.2
	Female	99.9	78.0	57.6	47.2	282.7
	Total	186.5	140.0	98.4	77.0	501.9
1970	Male	97.2	65.3	38.6	28. 2	229.3
	Female	110.7	85.3	59.2	48. 6	.303.8
	Total	207.9	150.6	97.8	76. 8	533.1
1975	Male	107.6	73.3	40.7	29.7	251.3
	Female	122.7	94.6	64.9	53.3	335.5
	Total	230.3	167.9	105.9	83.0	586.8

173. With present total population of 487,500 aged 65 and over, it can be seen that the expected increase by 1975 will be approximately 20% of the present numbers. In terms of percentage of the total population of Ontario, the following figures are charted by the Ontario Department of Economics:

Number aged 65 + 1956 - 454, 375 = 8.4% of total population 1966 - 504, 000 = 7.2% of total population 1971 - 555,000 = 7.0% of total population 1976 - 627,000 - 7.0% of total population

174. 2) Housing - Homes for the Aged - As of September 1961 the following statistics are available re homes for the aged. There are two types of homes - (i) those organized by the municipality and (ii) those which are considered charitable institutions. In Ontario there are a total of 55 municipal homes and 60 charitable institutions with the population breakdown as follows:

	Municipal Homes		
	Normal Care	Bed Care	Special Care
Male	1,563	796	767
Female	1, 247	1,699	927

Total: Male: 3,036, Female: 3,873 = 6,909

	Charitable Institutions		
	Normal Care	Bed Care	Special Care
Male	1,218	76	130
Female	2,119	203	244

Total: Male: 1,424, Female: 2,566 = 3,990

- 175. It should be noted that at present there is no routine psychiatric assessment made prior to admission of a prospective resident. Only in cases where there is overt behavioural disturbance will a psychiatrist's services be requested. In most cases the psychiatrist consulted is a local practitioner. In the case of the Metropolitan Toronto Homes for the Aged and the Toronto Jewish Home for the Aged, there are available part-time staff psychiatrists. The Homes for the Aged Act (Revised 1949) provides for:-
  - a building program with 50% of costs of new construction paid by the province.
  - 2) Admission for
    - a) ambulatory persons needing a measure of care.
    - b) persons confined to bed but not requiring medical treatment.
    - c) persons with mental handicaps where admissions to hospital is not indicated.
  - Attention to the standard of care re up to date facilities, attractive decor, comfortable furnishings, etc.
  - 4) Elimination of "institutionalizing" the residents by
    - a) architectural planning re rooms having no more than four beds and many with one or two, and
    - b) by eliminating the old system of committing persons to homes.
- 176. The objectives are admirable. What, in fact, these changes have wrought in terms of the resident's perception of his own role in such homes, could only be assessed by a detailed study involving a number of such homes.
- 177. The medical philosophy underlying the care of the residents in these homes is stated as, "the type of medical, nursing care to be provided

is that which will encompass maintenance care of stabilized illness that does not require a high intensity of skilled nursing or laboratory assistance." (C. K. Stuart, M.D.)

- 178. In connection with Homes for the Aged, mention should be made of the Geriatric Study Centre operated by the Department of Public Welfare in conjunction with Metropolitan Toronto. It is run after the fashion of an outpatient clinic. The source of patients is limited to 1,850 residents in the 4 Metropolitan Toronto Homes for the Aged. It is comprised of 12 clinics under the direction of a specialist in the particular field.
- 179. No estimate is available of the incidence or prevalence of mental illness in Home residents. This might prove to be an enlightening area for research but at present, personnel do not seem to be available to pursue this.
- 180. Recreational facilities appear to be available in most (98%) of Homes for the Aged. These include handicraft, tuck shop, beauty parlour, entertainment (passive and active.) Many homes have a liaison with local community groups (ladies' auxiliary, church, civic, sewing clubs) who come in as visitors or volunteers in assisting with programing.
- Resources of Older People in Ontario," prepared in 1959, it was stated that housing for the aged was a problem which required study.

  According to a Dominion Bureau of Statistics survey of incomes, assets and debts in 1955, 86% of the home owners 65+ in the sample owned their homes clear of mortgages. This of course was a cross-Canadian survey. In Ontario, in 1959, they stated that as many as 20,000 aged

persons lived in various institutions including Ontario Hospitals,
hospitals for chronically ill and Homes for the Aged. The number of
aged persons living with family members, particularly children, was
not known.

- 182. According to the 1956 census, 45,000 aged people lived alone 2/3 of this group were women. There were indications that many of these were roomers or lodgers in urban centres.
- In order to alleviate exorbitant rentals and overcrowded accommodation, nearly 1,000 low rental dwellings, apartments or low-housing units were erected for old people in Ontario between 1945-1959. This was performed under Section 16 of the National Housing Act. During 1960, an additional 300 units were erected. Waiting lists are long, however, and it has been noted that units are sometimes located in unfamiliar surroundings (true of some homes for the aged) and at some distance from stores and public facilities. Rent for these units run from \$35. (single person to \$60. (married couple.) In many instances these rentals are beyond the means of the people for whom they were designed. The developments can produce "in-grouping" by virtue of their residents segregation from other age groups. According to the report "experience has shown that segregation of age levels is a mutual disadvantage for all concerned." Again, this raises the issue of a possible research project designed to investigate the potential from the point of view of mental health or illness inherent in these developments. No estimate of geriatric population in nursing homes was available. Recently, the Ontario Hospital Services Commission has tended to withdraw its financial support from most nursing homes.

184. 3) Hospitals - For the calendar year 1960 the following statistics

were made available re geriatric patients in Ontario Hospitals;

	M	F	Total
No. of first admissions 65 and over	er 550	629	1,179
No. of first admissions all ages	2,820	2,530	5,350
Percentage	20%	25%	22%
Readmission 65 and over	110	189	299
Readmission all ages	1,422	1,581	3,003
Percentage	8%	12%	10%
Deaths 65 and over	579	633	1,212
Discharges 65 and over	259	302	561

Information re length of stay in hospital and to where patients were discharged (e. g. home, Home for Aged, Etc.) was not available.

There is a flexible arrangement between Ontario Hospitals and local Homes for the Aged which makes it possible for transfers in both directions to be made. It is estimated that at present more than 1/5 of the total population in Ontario Hospitals is comprised of aged 65 and over.

186.	In 1958:	Total pati	ents in	residence	in hospital	=	21, 130
		Total num	ber of	age 65+ in	hospital	=	4,559
		% no. of a	aged 65	+ in hospi	tal	=	21.6%

This proportion has increased 4 to 5% since 1949 when the percentage of aged 65+ in Ontario Hospitals was 17.0. The diagnostic syndromes which form the bulk of geriatric cases are:

- those admitted in later life with a mental disorder due to organic disease.
- those admitted at an earlier age with a chronic unremitting functional psychosis.

These data confirm the widely held opinion that some change in admission policy and/or provision of other facilities is necessary to cope with the overloading of Ontario Hospitals by the geriatric population. 187. Psychiatric Units of Public Hospitals - Figures for the period 1955-57 are available. Since this time more general hospital units have been developed with an expected increase in numbers of patients treated.

Aged 65+	1955	Male 1956	1957	=	emale 1956	-	<u>To</u> 1955	<u>tal</u> 1956	1957
Number	58	70	78	92	103	117	150	173	195
%	6.4	7.8	9.5	7,7	7.8	8.4	7.1	7.8	8.8

Total Number: 518
Total %: 8.0

There are no figures available to indicate the size of the geriatric population receiving R on the general wards and outpatient facilities of the general hospitals. In many instances this number would include psychiatric problems.

- 188. 4) Psychiatric Facilities Available for Geriatric Patients In general there are no specific units in Ontario which have as their express interest the care of geriatric psychiatric cases. Most of the outpatient clinics, (provincial and community,) day centres, and Mental Health clinics will provide as part of their overall service program diagnostic and treatment facilities for geriatric patients where indicated.
- 189. <u>During the calendar year 1960</u> The following clinics reported their new cases seen in the 65+ age group the following data are available:

		Aged 65-74		Aged 75+		Total
		<u>M</u>	<u>F</u> _	M	<u>F</u>	
1.	Brockville O. H.	5	5	4	3	17
2.	Hamilton O. H.	_	2	_	-	2
3.	Kingston O. H.	2	1	1	-	4
4.	Kitchener K-W					
	Hospital	9	14	5	5	33
5.	London O. H.	2	2	1	1	6
6.	London Victoria	15	22	7	9	53
7.	New Toronto O. H.	1	-	1	1	3
8.	North Bay O. H.	-		-	-	0
9.	Ottawa Civic	-	3	-	-	3

		Aged 65-74		APPENDIX	280 (39)	
				Aged 75+		Total
		M	F	M	F	
10.	Peterborough Civic	2	5		3	10
11. 12.	Port Arthur O. H. St. Catharines	9	9	5	2	25
	General	10	12	4	3	29
13.	St. Thomas O. H.	3	3	-	-	6
14.	Sarnia	-	2	-	1	3
15.	Toronto O. H.	2	7	1	1	11
16.	T.P.H.	4	11	1	1	17
17.	Whitby O. H.	3	5	-	2	10
18.	Windsor	-	3	2	-	5
19.	Woodstock O.H.	1	-	-	2	3
Day	Care Centres					
Cobo	ourg	2	8	-	_	10
T.P	. Н.	4	4	-	-	8
Toro	onto Forensic	1	-	with	-	1
Men	tal Health Clinics					
Otta	wa General	_	1	1	1	3
Toro	onto	-	1	-	-	1
Spec	ial Services					
Ham	ilton M. H. C.	-	-	-	-	0
TOT	'AL:					263

- 190. 5) <u>Community Services</u> Throughout Ontario there are 33 centres where various community services are mobilized for aiding the geriatric population. Unfortunately the number of people that are annually serviced by these organizations are not available.
- 191. As an example of what is being done in a large metropolitan area to this end - we can examine the report of the Social Planning Council of Metropolitan Toronto. (January 1961) They suggest that basic community services for older people are:

## 192. 1. Information and Referral Services:

-to ensure that older people know what services are available and to assist them in getting the services best suited to solving their problems.

### 2. Day Care Centres:

- in order to provide preventive and rehabilitative services to the elderly.
- to maintain and restore physical and mental health by providing a co-ordinated program of group activities and/or sheltered employment, counselling, meals, health services, etc. Its overall purpose should be more than just recreational in nature.

## 3. Counselling and Casework:

 for guidance in matters of family relations, living arrangements, budgeting, declining health, bereavement, separation.

## 4. Home Help Services:

- whereby part-time homemakers assist in cooking, shopping, cleaning, personal care. (In England and U. S. there is provision for "Meals on Wheels" - provision of hot meals delivered to older shut-ins.)

## 5. Friendly Visiting:

- a corps of volunteers visit.
- 6. Guardianship, Protective Services, Legal Aid:
  - particular care is needed to protect vulnerable old folks from poor or reckless investments.
- 7. Recreational and Educational Services.
- 193. To these ends the Social Planning Council, various religious, ethnic and service groups are actively involved in helping to provide the above facilities. A listing of services and involved groups follows:

#### 1. Information:

- a) Social Planning Council
- b) Scarborough Senior Citizen Service Bureau
- c) Housing Authority
- d) Various Governmental Branches

#### 2. Day Care:

- a) Women's Sheltered Workshop
- b) Day Care Program (Jewish Home for the Aged)
- c) Second Mile Club
- d) Good Neighbours' Club

#### 3. Case-work:

- a) Catholic Family Service
- b) Jewish Family & Child Service
- c) Neighbourhood Workers Association
- d) North York & Weston Family Service Centre
- e) Samaritan Club
- f) Department of Public Welfare
- g) Church Social Service
- h) Salvation Army
- i) C. N. I. B., etc.

#### 4. Home Help Services:

- a) Provincial and Municipal Services
- b) Visiting Homemakers Association
- c) Canadian Red Cross Society
- d) Commercial Housekeeping Services

## 5. Friendly Visiting Services:

- a) Second Mile Club
- b) Canadian Red Cross Society
- c) Shut-ins Friends Association Inc.
- d) Church sponsored Friendly Visiting
- e) Health Agencies

### 6. Protective Services:

- a) Public Trustee
- b) Mental Incompetency Act
- c) Power of Attorney
- d) Old Age Security Act
- e) Public Assistance Legislation
- f) Law Society of Upper Canada Legal Aid Clinic

#### 194. 7. Comments re Psychiatric Facilities:

From the foregoing it is clear that psychiatry is not "Geriatricallyoriented" in Ontario. In the Ontario Hospitals, we find an abundant aged
population but virtually no specialization in the approach to their
problems. Inasmuch as "old age" is a life epoch as is "childhood"
or "adolescence," it probably deserves to have psychiatry concerned
with directing its efforts toward it in a specialized manner. Throughout
the province, Clinics and Day Centres report small numbers of
people aged 65+ on their records – but again, there exists no special
geriatric clinics of a psychiatric nature in any community. It would
seem worthwhile considering the development of 3 or 4 such clinics,

strategically placed throughout the province, as pilot studies.

Initially for practical purposes it might be necessary to use existing clinic facilities where such patients could be seen.

- 195. The problem of interesting psychiatrists, psychologists, social workers, occupational therapists, in working with this age-group looms large. Sentiments advocating a custodial approach to the aged prevail. Yet it has been the experience of many workers in the field that
  - 1) elderly people with some forms of psychiatric illness recover, and
  - the encouragement of self reliant attitudes in members of this
    age group through a variety of planned activities brings its
    share of rewards.

In clinic settings, O. T. and group workers might be key personnel who could help provide programs designed to meet the needs of the geriatric group. Central to the issues of facilities and personnel is the need for a geriatric orientation. That is the needs of the aged with their special bio-psycho-social problems must be kept in mind in designing plans for helping them.

- 196. Consider firstly the requirements:-
  - 1. In Hospital At present there are no separate facilities provided for old folks in Ontario Hospitals. They are either infirmary-bound or placed in general wards depending on their physical status.

    Consideration might be given to the housing of geriatric patients in separate units or buildings where attention to architectural design could be incorporated into the planning. The following features are worthy of attention;

- 197. 1) a) equipment for personal grooming
  - b) ironing boards and irons
  - c) tilted mirrors in lavatories for wheel-chair patients
  - d) guard rails in corridors and both sides of stairs
  - e) low-rise stairs (5 inches)
  - f) ramps to outside exits
  - g) radiant heat to provide even, draft-free heat
  - h) chairs of right height
  - grab bars and non-skid floors in lavatories, showers and dressing rooms
  - j) more and better artificial lighting for reading
  - k) bed-sitting rooms for more bed-rest during the day
  - l) ground floor wards
  - m) wards with recreational and social activities geared to age and physical activities of patients
  - more single rooms and small dormitories with facilities for private belongings.
- 198. 2) A geriatric psychiatric unit or building should be in close liaison with a geriatric hospital where attention to physical illness could be given.
- 199. 3) Good nursing care is an essential service required particularly for bed patients who require frequent position changing, individual feeding, catheter irrigation, etc.
- 200. 4) Hospital size is probably therapeutically less important than personnel patient ratio. Personnel include both professional and non-professional help. Each community should make efforts to enlist the aid of volunteers who can help stimulate

activity even in some deteriorated senile patients. Use of music, dancing, rhythmic movements, simple repetitious jobs (winding a ball of string) serve to stimulate social involvement.

- 201. 5) Skilled clinical assessment. This is of particular importance in differentiating affective and chronic brain syndrome disorders.

  The work of Roth, Kay and others point to the value of use of ECT and/or appropriate psychopharmacological methods in treatment of affective disorders.
- 202. 6) It should be noted that the concept of "separation" re geriatric buildings, etc., is not universally held and some advocate a more integrated (with younger patients) arrangement. The thesis of this report is that this concept denies the uniqueness of the aged person and his illness and precludes a specialized approach to therapy.
- 203. 2. Domiciliary Care The work of MacMillan at Mapperley in Nottingham, England, illustrates how the family doctor, family, social worker, psychiatrist, use of day centres, and community support can help to maintain a mentally ill aged person at home. More extensive use of the Day Centre concept is suggested. Staffing of such centres might be concentrated on employment of O. T. and group workers interested in the aged, and as well, volunteer participation. Old folks can often manage to continue on at home for long periods even though their behaviour had been disturbed and apparently beyond the family's endurance previously. The use of this type of facility might of course substantially decrease rate of hospital admissions. Perhaps, a practical approach to transposing this concept to

Ontario would be to establish a pilot-project in a suitable area.

Instituting such a program in a community with an established Ontario

Hospital would permit statistical comparisons re admission rates, etc.,

after a period of two or three years.

- 204. 3. Emergency Facilities The need for a 24-hour mental health service for management of acutely disturbed patients is being thought of in more serious terms at present. Some such short term treatment facility for geriatric patients who present with toxic confusional states would seem indicated. Again such provision could be made as part of an overall therapeutic program set up in a Geriatric Mental Health Unit as was earlier proposed in association with present ontario hospitals.
- 205. 4. Outpatient Facilities These should serve as screening facilities where diagnostic procedures are carried out. Supportive therapy (psychotherapeutic, psychopharmacological, also would be practised where indicated.)
- 206. 5. Conclusion A philosophy of therapeutic nihilism for aged patients can only maintain the trend which emphasizes custodial care. The facts seem to indicate that many geriatric patients can benefit from active therapeutics and programing. New concepts, interesting experiments in treatment, etc., should be constantly noted for possible incorporation into facilities for the aged in Ontario. It is true that there are many geriatric patients to whom nothing more than custodial care can be offered. Perhaps the locus of such maintenance care should be nursing homes. Hospital facilities as far as possible should emphasize active treatment.

207. The APA report on patients over 65 in public mental hospitals makes the following significant points:-

"More intensive physical care and attention to these aging bodies, a whole program for the care of their emotional and social needs should be developed. The fact that people are living longer should be taken into consideration and the declining years should be made as productive as possible. Every effort should be made to discourage the "dumping" of aged patients on the state hospital facilities. The aged should be handled on an open ward basis wherever possible. They should be encouraged to preserve their skills, social graces and outside interests as long as possible. Every effort should be made to make the aged individual feel that he is still necessary and is wanted."

- 208. Commentary on Health Services for Alcoholism and other Addictions

  (by Dr. John D. Armstrong) (Appendix 6)

  Summary of Contents and Recommendations
  - Alcoholism, a disorder afflicting more than 200,000 Canadians is defined and a brief history given of recent endeavours to deal with it in Canada.
- 209. 2. The nature and extent of alcoholism is discussed, noting that present treatment can only arrest, suspend or palliate the condition, leaving an underlying illness that can, as with cancer, T.B. or malaria, or diabetes, be reactivated at any time.
- 210. 3. Present and proposed health facilities in relation to alcoholism are discussed under the headings or groups of headings from the

terms of reference of the Royal Commission on Health Services, as follows:

- 211. a) Existing Facilities and Methods for Prevention, Diagnosis, Treatment and Rehabilitation: Prevention dependent on emotional health, social attitudes, early case-finding, etc., treatment resources include not only specialized clinics but also wide variety of persons and institutions existing primarily for other purposes.
  - b) Methods of Improving Service.
  - c) Correlation of any new or improved program with Existing Services.
  - d) Personnel Requirements:- Main need is for systematic expansion of number of professional personnel with specialized experience in alcoholism field.
  - e) Methods of Providing ..... Training and Qualifications:- calls for systematic development of interest within schools and universities, plus provision of more fellowships and internships within institutions specializing in alcoholism; also provision of field consultations by present alcoholism programs.
  - f) Physical Facilities:- Requirements not great, since most of problem can be handled on outpatient basis; some enlargement of clinical facilities needed, and major metropolitan centres need special drying out centres.
  - g) Estimated Cost.
  - h) Methods of Financing Present and
  - i) New or Extended Programs:- Need proper standards as to what treatment is insurable; also sharing of cost of treatment for indigents by federal and provincial governments; plus money for fellowships, etc., to develop professional personnel.

- j) Relationship with Medical Research and Scientific Development:-Need federal health research grants; also support for the new Canadian Foundation on Alcoholism.
- 212. 4. Motivation, Legislation and Prevention: calls for revision of legislation governing commitment for treatment, increases in federal excise taxes on alcoholic beverages, and revision of criminal code sections related to driving after drinking.
- 213. I Alcoholism has been defined by the World Health Organization as the condition exhibited by:

"Those excessive drinkers whose dependence on alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily or mental health, their inter-personal relations and their smooth economic and social functioning."

- that once such people have the condition described, they are then sick people who in one way or another are costly to their country. It is known for example from sample studies that alcoholic employees in industry are about 6% of all industrial employees and have average annual absenteeism records that are from 10 to 20 days in excess of the normal. It is known too that one-quarter to one-third of the caseload of the average family service agency involves families in which some member's alcoholic behaviour is a factor. Similarly, we have studies indicating that about one-quarter of all persons convicted of impaired or drunken driving are likely to be alcoholics.
- 215. The question arises as to whether or not such people were in some way sick before they ever became alcoholics. Since the number of

alcoholics represents about 3% of those Canadians who do use alcoholic beverages, in what way do they differ from the other 97%.

- 216. There are eminent authorities who maintain that psychological factors predispose some individuals to alcoholism; and there are others, equally eminent, who believe that there is some biological or biochemical factor as yet unknown that differentiates the susceptible individual from the normal. The true answers which may yet be found to involve both types of factors can only be discovered by a great deal of further research. Meanwhile, there is clearly some addiction liability involved in use of the substance alcohol.
- 217. Some gain will certainly accrue from any activities that prevent the development of alcoholism in a person, as well as from activities that restore some alcoholic individuals to a state of health and usefulness.

  Both kinds of activities fall within the health field; yet it is difficult to be more precise and assign alcoholism totally to any single section of the health field. It is not purely a mental health matter; yet there are too many psychological and social variables involved to make it a matter of purely physical or internal medicine.
- 218. It is therefore respectfully submitted that Canada's and Ontario's resources to deal with this disorder merit specific and separate attention on the part of any inquiry into the needs of Canadians for health services.

## 219. II Recent History

In earlier generations it was possible to find, especially within the medical profession, some persons who regarded alcoholism as

- an illness. 1 However, such an idea has only become more generally acceptable during the last two or three decades.
- 220. Beginning during World War I and continuing for various lengths of time, the production and sale of alcoholic beverages was prohibited throughout much of North America. While there is little doubt that prohibition made alcoholism more nearly impossible for many people, such a method of minimizing the problem had other effects which made it unacceptable.
- 221. As a result, one province after another re-introduced the legal sale of beverage alcohol. It would appear now that the post-prohibition provincial controls over beverage alcohol distribution had two main consequences. In the first place they established a large and dependable new source of government revenue. Secondly, the price levels established were for a number of years high enough to make excessive alcohol consumption economically more difficult for the average citizen than it is today.
  - <sup>1</sup>In 1873, the Ontario Legislature passed an act to provide for the establishment of a hospital for the reclamation and cure of habitual drunkards and appropriated \$100,000. for a 78-bed hospital. The hospital, however, was never used for that purpose.
- In 1935, a new phenomenon occurred: Alcoholics Anonymous came into being in Akron, Ohio. What this event meant was that, although up to that time it had been generally regarded as hopeless for anyone to effectively help an alcoholic, it now became apparent that some alcoholics could help each other. This discovery automatically

ruled out the then prevailing view of alcoholism as hopeless. Canadian membership in Alcoholics Anonymous is now about 10,000.

- 223. In 1949, the Legislature of Ontario established the Alcoholism

  Research Founcation. This was in effect that first official attempt
  by a Canadian province to deal with alcoholism as a separate health
  problem. During the early fifties this was followed by the
  establishment of similar organizations in the four western provinces,
  and in 1960, in Quebec and Nova Scotia. Since these provincial
  specialized organizations were started they have received requests
  for treatment from about 20,000 alcoholics.
- 224. The unknown amount of repetition and overlap involved in treatment of alcoholics outside the official provincial organizations (either in institutions or otherwise, and either by medical or other practitioners or within Alcoholics Anonymous) renders impossible any exact estimate of how many alcoholics receive treatment; however, it is generally believed that at present not more than 15 percent of the affected population is receiving the kind of help that it needs.

# 225. III Nature and Extent

Research and treatment experiences during the past decade have made it increasingly clear that within the broad conception of alcoholism there are numerous different kinds of disorder. However, medical

Recently renamed the Alcoholism and Drug Addiction Research Foundation.

science is still in a process of determining what these are. From among the many varieties of alcoholics it may be useful to group those who are clearly addicted (and hence unmistakably ill) into two main classes:<sup>2</sup>

- those drinkers who, whole they can easily control the amount of alcohol they will consume on any one occasion, are unable to tolerate complete absence of alcohol from their system;
- those drinkers who, while quite able to do without alcohol for indefinite lengths of time, are unable, once they begin drinking, to control the amount they will consume on that occasion.
- 226. In certain countries, principally wine-growing areas, the first of these two classes of alcohol addicts appears to predominate, although not to the complete exclusion of the second class. In Canada, on the other hand, and in fact in most of North America, the first of these classes (those unable to do without regular dosage) is encountered less often; while the second class (those unable to stop drinking once they start) is most common among patients seen in our various Canadian clinics.
- 227. Given the present state of knowledge, once a person's ability to control his or her intake of beverage alcohol has been impaired, in either of the two senses described above, this impairment is permanent in nearly all cases. Present treatment can only arrest or suspend or palliate the condition often for the remainder of a lifetime, nevertheless the individual's underlying illness, his

Along lines recently suggested by Dr. E. M. Jellinek, the acknowledged world authority on alcoholism who has been working in Canada for the past three years. Dr. Jellinek also suggests several other classes of lesser prevalence.

addiction liability, remains and may at any time be reactivated; hence the alcoholic can only in extremely rare cases resume normal limited social drinking without a relapse. In this sense alcoholism, as a public health problem, resembles such disorders as cancer, tuberculosis, malaria or diabetes.

- 228. Like cancer or tuberculosis, most varieties of alcoholism have a tendency to progress and to become chronic, although alcoholism is not as rapidly fatal as cancer nor as easily arrested by relatively simple drug and rest treatment as are many cases of tuberculosis.

  However, alcoholism handicaps or disables about five times as many people as either of these other two diseases.
- 229. IV Existing Facilities and Methods for Prevention, Diagnosis,
  Treatment and Rehabilitation in Ontario

Prevention of alcoholism would appear to depend on:

- i) the general emotional health of the population;
- ii) social attitudes towards excessive drinking:
- the character of general knowledge about alcohol use that is acquired from educational and family background;
- iv) factors affecting the accessibility of alcohol;
- laws regarding alcohol related offences and the nature and consequences of their enforcement;
- vi) early diagnosis and case finding work.
- 230. Efforts to affect the first three of these are necessarily long-term endeavours for the benefit of future generations. The many influences affecting (i) the general emotional health of the population are undoubtedly discussed extensively in numerous other submissions being made to this Commission.

- With regard to (ii) social attitudes towards excessive drinking and (iii) general knowledge about alcohol, the various provincial alcoholism programs are active in the work of influencing public opinion and educational policy toward better understanding of the risks of alcoholism. Generally speaking, the organizations represented here use approaches that are based neither on fear nor on general condemnation of drinking but are based instead on research-based facts and on a perspective viewpoint that is felt to be realistic in a society in which some two-thirds of the adult population make some use of alcoholic beverages.
- 232. The role of (iv) factors affecting accessibility of alcohol is not entirely clear, but certainly the most influential one is the price of alcoholic beverages (relative to personal incomes and other prices.) Generally speaking this has, in real income terms gone down in recent years, a fact which is not apparent just from absolute dollar price levels.
- 233. (v) laws regarding drunkenness and alcohol driving offences, while theoretically deterrents to alcoholic behaviour, are very unevenly enforced.
- 234. Generally speaking, statutes against drunkenness refer to drunkenness in a public place; consequently their enforcement is by and large confined to occasions when they provide a convenient way of maintaining public order or of removing vagrants from the streets. The person who gets dangerously drunk in private cannot be touched by these laws, and in any event it is questionable that routine jail sentences and/or fines contribute very much to the rehabilitation of the offenders.

Nevertheless, repeated arrests for drunkenness do contribute to inducing some very small fraction of those dealt with to become involved in treatment of their addiction.

235. The alcohol driving offences (impaired driving and intoxicated driving) are only very loosely defined in law and the attaining of quantative evidence that alcohol levels can be blocked by the accused, except possibly in Saskatchewan. In their present form, therefore, and as presently administered, these laws are in our opinion not as effective as they could be, either in preventing accidents or in encouraging sensible limitations of drinking.

## 236. Province of Ontario - Outpatients Treated and Staff

1. \*Outpatients Treated:

(1) New 1,000

(2) Carried over 0

2. \*\*Staff:

Psychiatrists 3
Physicians 7
Nurses 10
Social Workers and Psychologists 8
Research and Education 16
Total 44

- \*included in the above patient figures are: 206 patients who spent short periods taking treatment for acute intoxication in general or other hospitals (and in some cases continued with other therapy); also 170 who spent a few weeks of their treatment as in-patients in one 16-bed unit at Toronto.
- \*\*Professional staff figures represent full-time or full-time equivalents, e.g. 2 half-time people shown as 1 full-time; the related administrative personnel are not included here.
- 237. The sixth factor, early diagnosis and case-finding work, has a bearing on both prevention and treatment. It is preventive, however, only insofar as it can make possible a recognition of incipient alcoholism

at an early enough stage to head off the development of complications or at least of a more deep seated addiction.

- 238. Recognition and diagnosis of alcoholism is not the monopoly of any specialized institution or profession. There is hardly a physician, or social worker, a clergyman, or even a lawyer, magistrate or judge in Canada who does not recognize alcoholism from time to time in some of those with whom he deals. In theory, most of these professionally-trained people can themselves do something to help the alcoholics they discover. In practice, very few will do so for several reasons:
  - a) unwillingness of the patient to accept help;
  - b) insufficient training and experience;
  - c) a feeling of hopelessness about the outcome;
  - d) where hospital treatment is indicated, a shortage of beds;
  - e) where long-term specialized therapy is indicated, a lack of knowledge of where or how to refer the patient.
- 239. With regard to the resources to which referral can be made under the last item, there are basically several possibilities. Cases can be referred:
  - to another practising professional known to have more experience in such cases;
  - b) to Alcoholics Anonymous:
  - c) to a mental hospital or mental health clinic;
  - to one of the limited number of privately or publicly sponsored clinics specializing in alcoholism and related problems.
- 240. The alcoholic, when sober, usually does not seem sick enough for institutionalization. Hence the alcoholism clinics which have developed in the past decade are largely outpatient facilities. As such they cannot be catalogued in concrete terms, such as number of hospital beds, etc., but only in terms of the personnel they have

- and the outpatients they see. The following table indicates the case load treated by Alcoholic Research Foundation Clinics in Ontario.
- 241. More complete data would also list the scattered facilities operated by religious organizations, reform institutions and those operated privately, some of which are in-patient units. In addition, about 10% of first admissions to mental hospitals are reported as alcoholic, and about 20% of readmissions. Mental health outpatient clinics, on the other hand, report very few alcoholic patients.
- 242. In addition, community general hospitals are used to some extent by physicians treating episodes of acute intoxication, but the proportion of such patients who proceed further to become involved in long-term treatment of the chronic aspects of their alcohol addiction has not been large. More recently, the shortage of hospital beds, particularly in rapidly growing metropolitan centres has made even straight detoxication treatment exceedingly difficult to obtain.
- 243. A proportion of physicians in private practice, of social agency personnel, some individual clergymen and some members of certain other helping professions are also in some cases of help to some alcoholics in their localities. Finally, the largest single source of help is the Alcoholics Anonymous movement.
- b) Methods of Improving Services, c) Correlation of any New or Improved Program with Existing Services, d) Personnel Requirements
  These three terms of reference are discussed together here, since even the existing specialized services in this field are relatively new.
  The specialized clinical facilities for alcoholics have been largely pilot or experimental projects, instituted on the assumption that

what these clinics learned could be transmitted and, as an eventual objective, put into use by health facilities throughout the country.

- This policy has been in part successful, in that one will now find in 245. Canada, both inside health institutions and outside, far more people than ever before who are competently and actively interested in helping to treat alcoholics. As one indication, a recent survey of physicians uncovered the fact that recently graduated physicians are seeing a good many more alcohol addicts than are older physicians. However, the task of spreading knowledge of alcoholism among local professionals has proved more difficult than those in the field had once hoped. Unfortunately, even those who do know what to do for the alcoholics they encounter tend to want to refer all but their simple cases to some public or private clinic which specializes in caring for such people. Specialized clinics therefore are not likely to disappear; however if they are properly used as training facilities they may very well need not much expansion of their capacity for patients. Large numbers of patients should eventually be able to get the help they need from the professional persons in their community who have received training from present specialized clinics.
- 246. General hospitals, tuberculosis hospitals, mental hospitals, public health units, mental health clinics, occupational health services, social agencies, reform institutions and welfare bodies of various kinds all of these need at least some staff having more than the usual competence and interest in alcoholic patients or clients. At the present time it is very difficult to estimate just how many specially

trained physicians, social workers, etc. these other institutions could use to improve their treatment of alcoholics. Reasonable estimates will only become possible after a variety of pilot projects had been under way for some time. Exploratory work now being done in this area by staff of provincial specialized alcoholism clinics needs considerable expansion.

- 247. Related to this is the need for treatment services in some federal institutions, notably penitentiaries, particularly since an increasing share of corrective work is being taken over by federal authorities from provincial services.
- 248. V Methods of Providing . . . Training and Qualifications

  This divides itself into several areas for discussion:
  - 1. From a prevention viewpoint, it is most important that school teachers, especially in secondary schools, be acquainted with and competent to deal with the most up-to-date approach to education about alcohol problems.
- 249. 2. Alcoholism treatment services, in common with many other health services, face enormous basic needs for expansion in the numbers of basically trained people in various helping professions.

  This requires that those in high school be encouraged to select such careers for themselves and to plan for the necessary university and professional training.
- 250. 3. Professional faculties need to be kept informed of the latest developments in the methods of treating alcoholism so that those being trained as physicians, social workers, psychologists, lawyers,

clergymen, etc., will in the future be better prepared for the acceptance of some responsibility in this field.

- 251. 4. At the post-graduate or interneship level, the alcoholism institutions presently in existence, both public and private, need to have sufficient fellowships and interneships available to enable them to supply appropriate clinical experience training to a great many more professional persons than are now receiving it.
- 252. 5. These same provincial and other alcoholism institutions need to have the resources to detach some of their personnel from their own clinics and make them available as consultants and organizers and instructors in the establishment of alcoholism programs within other institutions as discussed above.
- 253. f) Physical Facilities It follows from the discussions above that stress in the planning of specialized treatment facilities should be on their teaching capacity and their outpatient capacity, rather than on their bed capacity. There are two exceptions to this:-
  - research involving clinical investigation can most easily be developed in an in-patient setting; hence some in-patient units needed, mainly in teaching and research centres;
  - There is an increasing need for short-term bed capacity for the treatment of episodes of acute intoxication.
- 254. The present over-all shortage of general hospital beds is making (ii) short-term treatment exceedingly difficult. Steps being taken to increase the supply of hospital beds for all health purposes will in the long run make beds more easily available for alcoholism as well.

  Meanwhile, the establishment in larger metropolitan areas of special drying-out centres might actually reduce current pressure on the

general hospital bed situation and at the same time provide an opportunity to staff the treatment of acute intoxication with personnel having the interest and competence to steer the maximum number of such patients into longer term treatment of their addiction itself.

255. VI Estimated Costs: h) Methods of Financing Present Programs;
 i) Methods of Financing New and Extended Programs

1961 Budget for alcoholism program in Ontario is as follows:

Research	\$248,000.
Education	72,000.
Administration and	
treatment	451,000.
Total	\$771,000.

- 256. It is impossible to estimate the over-all cost of services to alcoholics outside the provincial specialized programs, because in almost every case they are unknown fractions of the cost of maintaining other services.
- 257. It is part of the nature of alcoholism that it interferes with the income earning capacity of those who need treatment. While some of the provincial programs have from time to time attempted to provide such treatment on a payment for service basis, this has resulted in a much larger bad debt problem than exists with most other health services, a situation which no doubt also prevails in relation to services rendered to alcoholics by physicians in private practice. Also, while some treatment is covered under various hospital and medical insurance plans, there is not a very consistent pattern in this regard since some plans permit claims for alcoholism treatment and others do not and the definitions of what is collectable change from time to time. It frequently happens that insurance payments are made for treatment

of acute intoxication without any effort being made to involve the patient further in any kind of long-term treatment which might prevent a recurrence - necessarily a costly process.

- 258. It is recommended, therefore, than an effort should be made to draw up standards that would be acceptable to professional authorities as to the type of treatment that would be considered insurable in this field, with a view to minimizing any avoidable repetition of purely palliative, short-term treatment.
- While a satisfactory and uniform plan for including alcoholism under various insurance coverages could absorb a good deal of the cost of treatment being provided for alcoholics, this disorder will inevitably involve many other people who, because of unemployment or unemployability, are not covered by insurance plans. Since the Dominion government derives in the neighborhood of \$250,000,000 from various forms of tax (including sales tax) on alcoholic beverages which is more than all ten provinces derive it seems reasonable to suggest that the costs of effective treatment for indigent alcoholics should be shared by the two senior levels of government.
- 260. Treatment of indigent patients should be paid for out of public funds on the same basis of acceptable standards, etc., as suggested above in relation to insurable treatment, i.e., on a service rendered basis to deal with the cost of staff and facilities for either outpatient or private therapy, both medical and non-medical, spread out over a considerable period of time for each patient concerned. In many cases, provision of such funds might be instrumental in rehabilitating the patients concerned to the point where they could again absorb the costs of insuring themselves.

- 261. Apart from the cost of day to day treatment, the physical and personnel plan involved in expanding treatment for alcoholism needs to be considered. While this has been regarded throughout as primarily an outpatient problem, some in-patient care is involved and for this reason, federal and provincial hospital construction grants should be made applicable to specialized alcoholism clinics meeting suitable standards. Any such contribution will tend to reduce the pressure on the part of the alcoholic population on the other forms of hospital facilities needed for other purposes.
- 262. By far the most important financial need in this field is some provision for the increase in the number of personnel acquiring the special training needed to deal with this problem. A substantial amount of money should, therefore, be made available for fellowships and interneships to be used for those taking post-graduate training as physicians, psychiatrists, social workers, etc., within provincial alcoholism programs.
- 263. From the viewpoint of prevention and case-finding, some funds should be made available to provide personnel trained in the problems of alcoholism for industrial or occupational health services and public health services.
- 264. VII Relationship with Medical Research and Scientific Development

  The principal hope of discovering methods of dealing with alcoholism

  on anything other than a small scale lies with research. While one or
  two of the provinces have established substantial programs of both
  intra-mural and extra-mural research in the alcoholism field

specifically, and while a certain amount of related research is being carried on in some mental institutions, there is in total far less research effort taking place in this field than in others.

- 265. The conventional research grant system, whereby applications from scholars for support for specific investigations are evaluated project by project, is insufficient to interest Canada's best scientific brains in working in this field. It presupposes that suitable scientists already have hypotheses to be tested that are relevant to this field. In actual fact a great deal of thought must still go into ascertaining the most productive questions that the scientist needs to ask.
- 266. Satisfactory development of scientific interest in alcoholism (or in the addiction problem generally) calls for the provision of moneys to universities and other institutions which they can use to set up continuing research development programs in this field. Only in this way can some continuity and orderly progress be ensured.
- 267. There is precedent for bloc grants for developing research institutions in the program of the National Institute of Mental Health, Education and Welfare of the United States which is actually supporting some

  Canadian research programs now. The Canadian government should seriously consider modifying its grant-making policies so that they provide leadership instead of haphazard assistance.
- 268. There is also the possibility that private subscriptions for research purposes can be mobilized through the proposed Canadian Foundation on Alcoholism which is now about to receive its charter, but which is as yet not a functioning entity. The Department of National Health and Welfare assisted in the formation of this group by providing facilities

for the original meeting which recommended the formation of such a Foundation in mid-1961. Since the founders of the proposed Canadian Foundation on Alcoholism (included among which are both private interests and the organizations collaborating on this present submission) have included among the objectives in a proposed charter the provision of central information services on research in this field and the development of a program of research grants, it seems appropriate to suggest that federal funds should be made available for administration by such a central organization as well as for administration through provincial health departments.

- 269. Motivation, Legislation and Education One characteristic of
  al coholism is the unwillingness of most of its sufferers to accept the
  fact that they are alcoholics. Provision of treatment services adequate
  to serve the alcoholic population will not automatically bring the patient
  to such services.
- 270. Traditionally it has been widely believed that most existing treatment methods could help only those who honestly and sincerely want to stop drinking. In the centuries since society stopped burning people for heresy, it has become pretty well accepted that you cannot force a person to change his inner mind. Yet this fact is not necessarily inconsistent with the fact that a variety of external pressures does enter into any radical change of heart or mind that takes place.
- 271. When a man or woman does finally decide that he or she wants to stop drinking, this decision reflects domestic, occupational, financial and even moral pressures which, together sometimes with physical complications, have overwhelmed his resistance. When all these

pressures fail, then in the best interest of those around the so-called recalcitrant alcoholic, it is the duty of the state to protect others from him. In addition, if our society believes that suicide – even slow suicide – should be prevented, then in the case of the advanced alcoholic there is again a clear duty to coerce him into protection if not into treatment. Once these duties are accepted, it becomes clear that present legislation (mostly provincial) governing commitment for treatment, needs considerable overhauling. A detailed study of this question has been published recently by the Medico-Legal Society of Toronto.<sup>1</sup>

- 272. From the viewpoint of preventing alcoholism, there are certain other measures which can be dealt with only by legislative action. In the first place, while research today fails to disclose a significant relationship between closing hours, number of outlets, the permit system, etc., and alcohol consumption, the pricing of beverages has a very clear relationship to consumption and to the prevalence of alcoholism. What has happened is that prices which were once high enough to deter excessive consuption have been overtaken by gradual inflation of incomes and of prices of other things to the point where beverage prices are no longer inconveniently high.
- 273. Any one province which might seek to rectify the above situation by raising beverage prices within its own jurisdiction will of course face difficulties at its borders. Such difficulties could be avoided, however,

<sup>&</sup>lt;sup>1</sup>The Criminal Law Quarterly - February 1959 - p. 442

simply by appropriate increases in federal excise taxes on beverages.

Judging from past history of price-consumption relationships in Canada in this field, a considerable increase in government revenue could result at the same time as a drop in alcohol consumption as well as a drop in the prevalence of alcoholism. The revenue increase involved might well be more than sufficient to finance all of the suggested services, training facilities, research grants, etc., reviewed in this submission.

274. The second preventive area needing legislative attention is that of the criminal law governing driving while intoxicated or abilities impaired by alcohol or drugs. Adequate measuring techniques are now available to make possible the establishment of "alcohol limits" comparable in legal significance to the speed limits which are posted on Canadian highways. Some people can drive safely at higher than the posted speed limits and others should drive more slowly; yet society accepts the existence of a speed limit law and expects it to be enforced within narrow limits of tolerance. The relationship of the posted speeds to safety is, if anything, less precise than the relationship between certain blood alcohol levels and a driver's statistical likelihood of becoming involved in an accident. It has been computed that on average, a driver's chances of having an accident are:

Normal with up to .05% blood-alcohol 1 1/2 times as great with .05 - .10% 2 1/2 times as great with .10 - .15% 9.7 times as great with .15% or more

275. It is, therefore, recommended that the criminal code be amended to make it:

- a) Not an offense to be in control of a vehicle with up to .05% blood-alcohol;
- an offence to be in control of a vehicle while having between .05 and .15% or more blood-alcohol.
- 276. It is our belief that this sort of quantification of the law will, if it is accompanied by legislation making it legal for police officers to require blood tests or equivalent breath tests from individuals involved in accidents, should have a marked effect not only on highway safety but also on the number of persons to drink more than a limited amount at any one sitting.
- 277. Assessment of Treatment Facilities for the Problem of Mental

  Retardation in Ontario (prepared by Dr. H. Frank) (Appendix 7)

With regard to the number of mentally retarded persons in the population various percentages are given, ranging from 1 to 7 percent. The generally accepted percentage of mentally retarded persons in a population in the Western countries is about 3%. This means that there are about 165,000 mentally retarded persons in Ontario. It is also generally estimated that about one-third of this group is under the age of 20 years. Accordingly, of the 165,000 mentally retarded persons in Ontario, 55,000 are under the age of 20. Of this group it is generally accepted that about 10,000 are severely retarded to the degree that they will always require a supervised environment.

278. In Ontario there are presently three hospital schools - at Orillia,

Smiths Falls and Cedar Springs. The last of these has just been opened
and presently accommodates about 300 patients. The hospital school at

Orillia, with the annex at Gravenhurst, is severely overcrowded and

has over 2,800 patients on its books. The hospital school at Smiths

Falls is also severely overcrowded, and presently has 2,500 patients
on its books. It is estimated that the condition of overcrowding is
over 25%. The hospitals at Orillia and Cedar Springs have between them
a waiting list of about 1,500 presently. The ultimate capacity of the
hospital at Cedar Springs will be about 1,000 beds. Furthermore,
there are over 5,000 mentally retarded persons in the Ontario Mental
hospitals. The need for expanded residential centres for the mentally
retarded, therefore, is obvious. The hospital schools have outpatient
departments for diagnosis and counselling.

- 279. Presently there is a diagnostic and counselling clinic for the mentally retarded at the Children's Psychiatric Institute at London, Ontario, which serves the population of Southwestern Ontario. Another such diagnostic clinic is to be set up shortly in connection with the outpatient department of the Toronto Psychiatric Hospital.
- 280. The various provincial mental health clinics also carry on a diagnostic clinic for mental retardation to a degree, and this is hampered by lack of staff
- 281. In the large centres, such as Toronto, Ottawa and Hamilton, community mental health clinics also carry diagnostic and counselling services.
- 282. There is a lack of diagnostic and treatment services for the mentally retarded in the north country. With regard to mentally retarded children who reside in northern Ontario and require residential treatment, such must come through the hospitals at Orillia and Smiths Falls frequently this involves a distance of over 1,200 miles.

- 283. There are about six private homes for mentally retarded infants in the province these accommodate 12 to 35 children each.
- every community with a population of over 15,000 provides auxiliary or opportunity classes for the mentally retarded within the public school system. Such special classes are practically non-existent in rural areas and in small towns. There is a marked lack of vocational training facilities in the school systems, also such are available only in the cities of Ottawa and Toronto.
- 285. The hospital schools provide a school program for the mentally retarded but it is felt that this is presently sub-standard, since such facilities are not related to the Department of Education.
- Statistics Number treated in community facilities. Certainly several thousand children are receiving education in auxiliary class programs of public school systems as mentioned above. The exact number is difficult to estimate, and certainly this area requires an adequate survey. About 1,200 severely retarded children are receiving training in special classes in about 70 communities in Ontario; these are under the jurisdiction of the Ontario Association for Retarded Children. Of this group, about 200 are receiving vocational training and are productive to a degree in a sheltered workshop setting.
- 287. Number treated in Hospitals There are about 5,700 mentally retarded persons in the three hospital schools, and there are somewhat over 5,000 in the ontario hospitals.

288. Professionals and non-professionals employed for the treatment and care of the mentally retarded

In the three hospital schools serving a population of over 5,300 mentally retarded, there are 14 physicians. This obviously is a very small number. Other professional personnel, such as social workers, psychologists, physiotherapists, occupational therapists and speech therapists show a similar lack. With regard to non-professional staff – that is nurse aids and attendants – there are about 1,500 in the hospital schools.

- a) Presently there is a <u>lack of residential facilities</u> for the care of the mentally retarded with very long waiting lists at the hospital schools. Planning is required to keep pace with the growing population of the province, and therefore with the counselling are also required, particularly in Northern Ontario.
- 290. b) With regard to personnel particularly the professional such are urgently required; not only for the present facilities but for the expansion of such. Possibly professional personnel might become interested in this field by more adequate educational programs in the problem of mental retardation as it affects all related professional disciplines this is required in University.
- 291. c) With regard to size and location of hospitals, it is our opinion that such should be established on a regional basis, with some close connection to a university. The size should not exceed 1,000 patients.
  Added to this regional residential centre, small residences accommodating 25 50 could be established in communities within the region. With regard to the design of residential centres, it is felt that such should consist of self-contained units of about 40 persons.

- 292. d) <u>Design of treatment program</u>. It is essential that a residential centre for the retarded supply a comprehensive program of medical care and rehabilitation. This envisages an adequate full time professional staff with added consultants in the various medical specialties.
- e) Role in the Community. It is felt that the community can assume more responsibility for the care and training of the retarded, both with regard to the school systems and the voluntary organizations such as associations for the mentally retarded. There is a need for the expansion of special classes for the retarded school systems, and possibly a mandatory legislation for the setting up of such classes.

  Voluntary organizations can assume an expanding role with regard to sheltered workshops particularly.
- 294. f) There is a dire need for basic research in the field of mental retardation, particularly in the fields of Biochemistry, Neurochemistry, Pathology and Cytogenetics. Also required is research in the field of special education and psychology with regard to investigating learning processes of the retarded and setting up of adequate curricula in an educational program.
- 295. g) Further suggestions are as follows:
  - Routine urinalysis for phenylketonuria in infants at the age of about one month.
  - 2) Avoidance of unnecessary X-radiation of pregnant women.
  - Pre-marital testing for Rh and other blood group incompatibilities.
  - Genetic counselling, particularly with persons in whose family there is a history of inheritable diseases causing mental retardation.

296. Survey of Research in Psychiatry in Ontario (prepared by Dr. John W.Lovett Doust) - (Appendix 8)

Research - Existing Facilities - The following statements are based on the accumulated responses to a comprehensive Province-wide survey recently carried out in Onfario. They include the experiences of 25 major university, hospital and clinic settings wherein research programs exist and comprise 24 units undertaking clinical research (Adult psychiatry; 8 in-patient, -10 outpatient, 1 day care; Children: 2; Mental sub-normality: 3); 5 units wherein drug trials are carried out; 8 clinical units wherein other special investigation procedures are carried out; 10 units for laboratory research devoted primarily to psychiatry; and 2 laboratory units for work focussing upon mental subnormality.

- 297. Within these 25 research settings, 96 programs have been recently initiated. They comprise 54 examples of clinical research (15 case studies, 6 epidemiological investigations, 6 follow-up studies, 7 studies involving group relationships, 10 drug studies, 1 investigation on individual psychotherapy, 4 on conditioning and related therapies and 5 on other therapies.) Laboratory-based research accounts for a total of 28 programs (12 in the general field of biochemistry, 5 in psychophysiology, 3 in cytology, 3 in clinical pathology, 3 in constitution and 2 in immunology. Clinical and experimental psychology accounts for 12 programs and social aspects of mental health for 2.
- 298. Employed on these research undertakings are 40 psychiatrists (6 full-time; 34 part-time,) 50 psychologists (2 full-time; 29 part-time,)

4 biochemists (3 full-time; 1 part-time,) one part-time neurosurgeon,
4 part-time social workers, 2 part-time speech therapists, one parttime occupational therapist, 18 nurses (4 full-time; 14 part-time,) and
3 part-time statisticians. Helping these professionals are 16 technicians
(11 full-time; 5 part-time,) 2 full-time statistical clerks and 11
secretaries (6 full-time; 5 part-time.) While gaining research
experience during their professional training, there are 8 part-time
psychiatrists-in-training and 6 other postgraduate students in training.

Research - Future Needs - The scope of current Ontario research in 299. the mental health field illustrates how wide are the involvements of psychiatry. In looking ahead to those areas demanding of increased research effort and ever more concentration of endeavour, Ontario's research directors emphasize the top priority need for increasing the tempo of purely clinical research, basic physiological and biochemical investigations, more social and cultural anthropological studies (including studies involving family relationships) and a greater effort directed toward improved treatment methods (including a better evaluation of existing treatment procedures.) Next in priority is seen the need for research into the aetiologic aspects of breakdown patterns, into psychotherapy, the evaluation of prediction of outcome psychopharmacology, epidemiology, the evaluation of existing practices in the management of the mentally ill, and more longitudinal studies of patients (including long-term follow-up.) Last but by no means least are the areas of preventive psychiatry, normative studies of growth, and development and constitution, semantics, perception, rehabilitation, and research into improving professional education.

- 300. In regard to the conditions and facilities needed to implement future research in the areas listed, it is obvious that much should be done to improve existing conditions. "More space, more people" is a constant cri du coeur from almost every centre presently carrying out research programs. Among the more cogent suggestions in this regard are the following:
- 301. 1. that more basic investigations and most laboratory studies be concentrated within research institutes forming parts of universities while hospitals and clinic settings focus principally upon clinical aspects of research;
- 302. 2. that closer liaison be established between university departments and research units in hospitals and clinics to improve the quality of research undertaken, to facilitate interdisciplinary studies and to improve the sophistication and education of aspirant research workers;
- 303. 3. that a greater number of full-time research workers be supported in the mental health field. As a corollary to this in Ontario, we would call for the abolition of the Grant-in-aid-Schedule and the establishment of rates of pay and tenure security equal to those enjoyed by similarly qualified psychiatric service workers;
- 304. 4. that increased flexibility in the use of research funds would facilitate the investigator's work;
- 305. 5. that bringing the professional establishment of mental hospitals,

  clinics and other institutions to an acceptable level (e.g. by improving

  the pay and conditions of service in psychiatry) would permit more

valuable part-time research undertakings to proceed than can take place under present conditions of understaffing;

- 306. 6. that some means be sought to enable interested postgraduate students to engage in research programs during their professional training, the time spent in this work remaining acceptable in terms of examinational requirements;
- 307. 7. that improvement in the availability of statistical help in psychiatric research becomes of greater importance each year and that such help involves both that of suitably qualified statisticians, technician-computers and statistical clerks as well as appropriate data processing apparatus.
- So far as personnel needs for the future are concerned, outstanding is that for more and better trained research psychiatrists. As recommended above, a moiety of these should be full-time career investigators but the need for experienced part-time research psychiatrists is equally great. Second only to well trained specialist psychiatrists motivated toward research and trained in scientific disciplines is the overall need for psychologists expert in experimental, social, developmental and clinical aspects of the mental health field. More specialized investigations call for psychiatric social workers, technicians and engineers, physiologists, biochemists and pharmachologists, sociologists and anthropologists, geneticists, and educationalists. Expressed by many Provincial research groups was a desire for some form of statistical consultation service where expert advice on experimental design could be had.

- 309. Summation of opinion regarding the <u>training</u> of personnel seeking to enter the investigative field of mental health brought forth many practical suggestions. Among the more attractive were the obvious ones, namely that an introduction to research methods and statistics be made a part of the formal postgraduate training of psychiatrists while opportunities for trainees to engage in ongoing research programs would both enlarge the putative scope of such programs and provide interest and motivation on the part of the trainee to put his own ideas to the tests of validation, reliability and usefulness.
- as to the <u>cost</u> of expanding the research activities across the province, estimates varied widely. Desirable additions to existing clinical units averaged amounts of some \$20,000.00 per unit per annum while the more ambitious and expensive additions to the facilities of University Research Institutes endeavouring to promote the more basic aspects of psychiatric research (as advised for the future by "Action for Mental Health," the recent report of the American Joint Commission on Mental Illness and Health,) additional sums of \$100,000.00 to \$120,000.00 per annum were suggested.

# 311. PSYCHIATRIC EDUCATION IN ONTARIO (Appendix 9)

- A. Postgraduate Psychiatric Training, Department of Psychiatry,

  University of Toronto
- I The number of doctors in postgraduate training each year between 1951 and 1961 is as follows:

1951-52	16	1956-57	34
1952-53	19	1957-58	48
1953-54	26	1958-59	42
1954-55	27	1959-60	52
1955-56	27	1960-61	57

The number of postgraduate doctors coming from П

a) Ontario

331 b) Elsewhere in Canada 5 (2 from Armed Services)

c) Outside of Canada

Ш A majority of those trained are likely to practise in Ontario.

IV The postgraduate course is of four years' duration.

 $\mathbf{v}$ A brief description of the curriculum is attached.

VI The teaching staff is as follows:

> Medical 50 Biochemistry 1 Neurophysiology 1 Nursing 2 Occupational Therapy 2 Philosophy 1 Psychology 4 Social Service 4 Social Psychology 1 Sociology 2 Speech Therapy 1

- 312. Postgraduate Psychiatric Training in psychiatry is offered to physicians selected on the basis of an adequate grounding in general medicine. One year rotating interneship and one year as senior medical interne are desirable prerequisites. The training is planned to cover a four years' experience in all aspects of psychiatry, and to achieve specialist status. Candidates will be expected to aim at the examination for Fellowship of the Royal College of Physicians of Canada or for recognition as a certified specialist. While in training the physician will be paid according to the post he is holding. Arrangements for training on a parttime basis will be considered in relation to individual circumstances.
- 313. At the present time the introduction to the four years' course will be undertaken at the Toronto Psychiatric Hospital. Later appointments, of six months' to one years' duration, will be arranged in the various

- departments of the Medical Faculty, and in community settings including children's agencies, courts and industry.
- 314. The Diploma in Psychiatry will be awarded by examination at the completion of two years' training.
- 315. <u>Curriculum for the Diploma in Psychiatry</u> The university provides
  a training leading to a Diploma in Psychiatry for graduates in
  medicine of this university or some other university recognized for
  the purpose by the Senate.
- a rotating service in a recognized general hospital; a further year's experience in general medicine is desirable. Exceptions may be allowed in special individual circumstances but selection will remain on the basis of merit and adequate preliminary experience. Physicians in the service of the Ontario Hospitals are eligible for application and would ordinarily be given special consideration.
- 317. The course for the Diploma in Psychiatry extends over two calendar years: these two years are arranged as an essential part of the four years' training to specialist status. Success in the Diploma Examination will facilitate further appointments within the Department of Psychiatry for graduates going on to the Fellowship or Certification examination of the Royal College of Physicians of Canada.
- 318. Instruction is provided on the basis of direct clinical experience and responsibility for ill people. The methods of the case conference, the seminar, and the discussion group are more emphasised than didactic lectures. Individual practice is developed by Tutors and Supervisors.

- also arrangement in the clinical and laboratory departments of the Faculty of Medicine, and in various community agencies. The training program is based primarily on the Toronto Psychiatric Hospital with extensions into the community, the general hospitals, the special hospitals, and the mental hospitals.

  Particular emphasis is given to the problems of children and the aged, to problems of the courts, industry and schools, and to such psychosomatic problems as the visceral neuroses, alcoholism and epilepsy.
- 320. In general the subject matter of the course includes:

Anatomy and Physiology of the central nervous system with particular emphasis on high level functioning.

Pathology in its structural and functional aspects particularly neuropathology and the pathology of the endocrine system.

Psychology including child development and behaviour.

Psychopathology and its clinical applications.

Psychosomatic medicine.

Clinical Psychiatry: the study of the settings in which the psychiatric problems arise; methods of approach to the problems; techniques of investigation; the psychiatric syndromes and their general management; methods of treatment; problems of psychotherapy; physical treatment and social therapy as they arise in both the outpatient and in-patient services.

Social Psychiatry as represented by a study of the family, the school system, the vocational field and the wider cultural groupings.

Preventive measures and the potentialities of mental health programs.

321. Funds are available to support the living costs of the graduate in training. Their sources are variable and they are subject to differing conditions. In general the funds are in the form of University Fellowships, Government bursaries, and paid hospital posts.

Information is available on request. Whatever the individual financing may be, university registration and payment of fees are compulsory.

The dues to the university for full-time or part-time instruction are \$95.00 for the first year, \$140.00 for the second year. Whereas failure in the examination does not preclude a subsequent attempt, the full examination and diploma fee will be levied on each occasion. No supplemental examinations are allowed.

- 322. Applications for admission should be made to the Secretary of the Department of Psychiatry, Toronto Psychiatric Hospital, 2 Surrey Place, Toronto. In most cases the candidate will later be expected to have an interview with the Professor of Psychiatry.
- 323. B. Training Program Department of Psychiatry University
  of Western Ontario
  - I Physicians in Training each year, 1951-1961 (Course became a reality in 1953)

1953-54	3	1958-59	8
1954-55	6	1959-60	6
1955-56	5	1960-61	6
1956-57	7	1961-62	8
1957-58	7		

The course is two core years under university setting. The above are only those students on this section of the course. In addition, most have one year in an Ontario Hospital before coming to core area and many remain for a year after completion of the university portion of their training. These are not included in the above list.

324. II Number of Postgraduate Doctors coming from Ontario, etc.

All were from Ontario at the time of registering, although a number

graduated from medical schools elsewhere before coming to Ontario.

- 325. III Number Likely to Practice in Ontario. Only the individual students themselves know the answer to this question and even they are often not sure. However, of those completing the course, all but one and possibly two have remained in the Province.
- 326. Length of Postgraduate Course. As noted above, two years. Each year we keep the outstanding student for a third year.
- 327. Description of Curriculum and Clinical Setting. (See attached material.)
- Size of Teaching Staff. As presently framed, this question is relatively meaningless. Actually there is only one member paid directly through the university. All other members are paid by and for other functions, and teaching is a by-product rather than a direct responsibility. The staff are psychiatrists and other members attached to the facilities listed below.
- 329. Comments Regarding Facilities: By Canadian standards our facilities are extensive and sufficient to provide a well-rounded training program. We have available within the area:
  - a) 3 Mental Hospitals (2 provincial and 1 D. V. A.) - approximately 5,000 beds.
  - b) 3 Open Psychiatric Wards in general hospitals (2 general and 1 D. V.A.) but with patient movement equal to mental hospitals total about 110 beds.
  - c) 1 Child Guidance Clinic associated with Childrens' Hospital.
  - d) 1 Mental Health Clinic.

328.

VI

Psychiatric Research Institute for Children (Retarded.) e)

- 330. The real problem is that although the membership available for teaching is now fairly extensive, all effort in this line is beyond the call of their regular duties. This puts a very clear-cut ceiling on the amount of time and effort that can be asked of any one individual no matter how willing and enthusiastic he may be.
- 331. Thus the real need is for the funneling of greater funds through the
  University Department of Psychiatry so that the available staff can
  be paid for the business of training and not leave this important aspect
  on almost a voluntary basis. Without this we function at a real
  disadvantage compared to many United States centres that have this
  type of organization.
- 332. 1. The graduate training program in Psychiatry of the University of Western Ontario is co-ordinated with the training scheme of the Mental Health Division of the Ontario Department of Health.
- 333. 2. This program extends over four years. The first and fourth years are spent in an ontario hospital. The second and third years are spent in the psychiatric wards of the general hospitals in close proximity to the university and under direct university supervision.
- 334. 3. Students coming on course should arrange for an appointment through the Director of Hospitals, Ontario Department of Health,

  Parliament Buildings, Toronto. If the student plans on coming to this university he usually selects either the Ontario Hospital, London or

  St. Thomas, for his first year. These hospitals are sufficiently close to the university that it eliminates the necessity of moving for the

university part of the course. In addition, both are approved for training due to their affiliation with the university.

- 335. 4. During the two central years in close association with the university, in addition to the clinical training provided on the wards, there are weekly psychiatric seminars on important subjects during the academic year and monthly psychiatric meetings in the various mental hospitals and psychiatric wards, etc., in the district. During this two-year period, students spend six months on each of the three open psychiatric wards in the general hospitals and the fourth 6-month period is left open for the student's special interest. There is opportunity for reviewing his Neuroanatomy in the Fall of the first year of the university segment of the course.
- 336. 5. The final year of the four-year period the student is allocated to an Ontario Hospital by the Ontario Department of Health.
- 337. 6. Students must have received an Enabling Certificate from the College of Physicians and Surgeons of Ontario and show evidence of ability to obtain their Licence to Practice in the immediate future before being accepted for training.
- 338. C. Postgraduate Psychiatric Training, Department of Psychiatry
  University of Ottawa
  - Number of doctors in postgraduate training each year between 1951-1961:

Year	University	Affiliated
1955-56	1	0
1956-57	2	0
1957-58	4	3

Year	University	Affiliated
1958-59	4	2
1959-60	4	2
1960-61	6	2
Current	9	4

339. II Number of Postgraduate Doctors coming from:-

a)	Ontario	2
b)	Elsewhere In Canada	1
c)	Outside of Canada	10

- 340. III Number of those trained likely to practice in Ontario 10
- 341. IV How long is the Postgraduate course:

4 years - 3 years in University Centre
1 year in Affiliated hospitals or academic posts.

- 342. V The clinical curriculum is divided into three years:
  - First year clinical training with psychoses in a mental hospital (Brockville or now the Royal Ottawa Sanatorium.)
  - b) Second year clinical training in general hospital psychiatric unit with half time devoted to supervised outpatient psychotherapy. Some experience in teaching of nurses and undergraduate medical students.
  - c) Third year six months child psychiatry and six months psychosomatic medicine, community psychiatry, forensic psychiatry, research or basic sciences in appropriate settings.

On each clinical service there are periods for ward rounds,

case conferences, individual supervision and guided reading.

343. In addition, the postgraduate student, during the three years, attends seminars in:

Psychiatric Nozology.

Treatment methods in Mental Hospitals.

Techniques of Interviewing.

Psychopathology and Psychodynamics.

Neuroanatomy and Neurophysiology.

Pharmacology.

Neuropathology.

Psychophysiology and Psychosomatic Medicine.

Social Psychiatry.

Psychological Testing.

Forensic Psychiatry.

344. VI Teaching staff includes:

Twelve clinical instructors - half to full-time in clinical settings.

Seminar instructors in basic sciences.

345. D. Postgraduate Psychiatric Training, Department of Psychiatry,

### Queen's University

I Number of doctors in postgraduate training:

1958	1
1959	2
1960	8
1961	10

346. II a) Number of postgraduate doctors coming from

Ontario

- b) Number of postgraduate doctors coming from elsewhere
- in Canada 1
- c) Number of postgraduate doctors coming from

Outside Canada

- 347. III Number of those trained likely to practice in Ontario 8
- 348. IV Length of postgraduate course:

2 "core" university years with supervision in another 2 years.

- 349. V Description of curriculum and clinical setting (timetable and brochure attached.)
- 350. VI Size of Teaching Staff:

# Psychiatry

Full-time 3 Part-time 7

### Clinical Psychiatry

Full-time 3

Part-time 0

#### 351. Graduate Training Program Schedule 1961-62

# Monday:

9-11 a.m. Adult Service Rounds KGH - Connell 4 (Dr. Sloane) Clinical and Experimental Psychiatry (Drs. Sloane, 3:30-5 p.m.

Laverty, Butler - C4)

Journal Club 8 p. m.

#### Tuesday:

9-10 a.m. \*Psychology 26 - Psychometrics (Dr. Dodwell) 10-12 Adult Service Rounds KGH - Connell 4 (Dr. Butler) 1:30-2:30 p.m. \*Introduction to Psychology (Dr. Payne)

3:30-5 p.m. Psychiatry Grand Rounds (Ontario Hospital)

# Wednesday:

Adult Service Rounds KGH - Connell 4 (Dr. Sloane) 9-11 a.m. 9:30-12 \*\*Child Psychiatry - Teaching Round KGH

Clinical and Experimental Psychiatry (Dr. Laverty -3:30-5 p.m.

Connell 4)

### Thursday:

9-10 a.m. \*Psychology 26 - Psychometrics (Dr. Dodwell) Adult Service Rounds KGH - Connell 4 (Dr. Butler) 10-12 1:30-2:30 p.m. \*Introduction to Psychology (Dr. Payne)

3:30-5 p.m. Psychological Research & Psychiatric Problems

(Dr. Inglis - C4)

# Friday:

8-10:30 a.m. Adult Service Rounds KGH - Connell 4 (Dr. Sloane) 10:30-12 \*\*Child Psychiatry Teaching Round (Dr. Rich) 2-3:30 p.m. Child Psychiatry (Dr. Rich - C4)

3:30-4:30 p.m. Psychotherapy (Dr. Rich - C4)

#### Saturday:

Adult Service Rounds KGH - Connell 4 (Dr. Butler) 10 a.m. -12 Neurological Grand Round 9-10 a.m.

\*Attendance desirable but not obligatory - Candidates will be required to pass an examination on these courses some time during the twoyear course. An examination will be held at Christmas for Dr. Payne's course and Dr. Dodwell's course.

\*\*Attendance desirable but not obligatory.

352. Requirements of Social Service Personnel in Psychiatric Practice (prepared by Mr. Cyril Greenland) - (Appendix 10)

Hard facts on the number of qualified social workers employed in
Ontario apparently do not exist and much of the available data amounts
to little more than poorly substantiated guesses. The Department of
Public Welfare has estimated that there are 1,750 "welfare workers"
employed in Ontario. Of these, 750, as members of the Canadian
Association of Social Workers, can be regarded as "qualified." It is
not possible to ascertain how these staff are distributed in the various
social agencies.

353. The attached tables provide the following information:

TABLES I: show the number of qualified social workers in

- A. Provincial In-Patient Services
- B. Provincial Outpatient Services
- C. Community In-Patient Services
- D. Community Outpatient Services
- E. Summary

(Data on Private and D. V. A. Hospitals and the Alcoholic Research Foundation are not included.)

TABLE II: shows Social Work Comparative Salaries at September 1961.

TABLE III: shows the number of students graduating with M.S.W. in 1961.

TABLE IV: shows Ontario Mental Health Bursary holders and the number presently employed in the Mental Health field in Ontario.

354. While the data provided by these tables is self-explanatory, the following comments on them may be helpful:

TABLE I - E. Shows that a minimum of 238 social workers are required to meet needs, based on existing case-loads. Expanding services or attrition are not accounted for in these estimates. However it should not be assumed that the present budgets would allow for the expansion of staff even if they were available.

- 355. In view of the grave shortage of professionally trained staff, a number of social work positions are filled by unqualified staff. Therefore, the number of vacancies are actually less than is shown in these tables.

  On the other hand, since the estimated staff requirements are far below the minimum standards suggested by the A.P.A. (June 1958), this fact is not particularly significant in calculating overall needs.
- 356. Although the shortage of staff is indeed substantial this fact should be balanced against the fact that in the past four years there has been fourfold increase in qualified social workers employed in the Provincial Mental Health Services. On the other hand, the geographical distribution of this staff is most unequal. The lack of professional staff in the Northern region is a matter of grave concern.
- 357. The fact that only 8 qualified social workers are employed in

  Psychiatric Units in General Hospitals should be noted. That none are

  employed in the teaching centres such as Toronto General, St. Michael's,

  Western and Women's College Hospital is particularly regrettable.
- 358. There is at present no data available to show the number of patients treated by psychiatrists in private practice. The extent to which these patients receive appropriate assistance with their social problems can only be surmised, but it is safe to assume that very few are referred to qualified social workers. This is probably also the case when patients are treated in Private Mental Hospitals.
- 359. TABLE II Emphasizes that not only are social work salaries poor, but the remuneration offered by the Provincial Civil Service is, in certain instances, lower than it should be when compared with other

agencies employing social workers. This is particularly so in the senior positions.

- 360. This fact is of considerable importance in relation to recruitment and stability of staff tenure. In order to reduce the attrition rates a substantial problem in social work, it is essential to offer salaries which will attract male staff and provide, through attracting career opportunities sufficient inducement for them to remain in the service.
- 361. According to the Dominion Bureau of Statistics (Ref. paper 71) between 1950-1955, 255 Canadian "Social Welfare Workers" emigrated to the United States of America. Since the traffic is mainly one way, this suggests that a large proportion of social workers are leaving Canada to enjoy the higher remuneration offered in the U. S. A.
- 362. TABLE III New graduates from the Schools of Social Work provide a substantial number of social workers for the various mental health facilities. This is in part due to the provision of bursary assistance. However, students are increasingly reluctant to accept bursaries with "strings attached." Many of those who do are unwilling to accept employment outside Toronto. There have also been some criticisms that the amounts offered, namely \$150.00 per month for nine months, is inadequate and that more generous bursaries should be made available for two years instead of only one at present. The National Health Grants Administration are unable to provide additional funds for this purpose at present.
- 363. TABLE IV Of the 62 students who received bursary assistance for social work training, 30 are at present employed in a psychiatric facility. This includes 8 who are obliged to return a year's service.

364. In reviewing this material it has become patently obvious that the supply of trained social workers is inadequate to meet existing needs.

The present rate of growth, although substantial, cannot provide enough qualified social workers to staff new services. Although substantially increased salaries will be a major factor in encouraging new recruits to the profession, an even more radical remedy needs to be sought.

Any unilateral solution which results in attracting qualified social workers to the Mental Health Services at the expense of Public Welfare or Child Welfare will, in the long run, only add to the burdens faced by mental hospitals, etc.

365. TABLE I - First Admissions, The Number of Qualified Social Workers
(A) and Estimated Establishment

Provincial Department of Health In-Patient Services:

Ontario Hospital and	1st Admissions	# of Social	Estimated(*)
Hospital Schools, etc.	1960	Workers	Establishment
Aurora	13	-	3
Brockville	373	3	12
Cobourg	53	**	3
Hamilton	704	7	12
Kingston	348	2	12
London	394	6	12
New Toronto	487	7	20
North Bay	394	1	6
Orillia	225	1	6
Penetanguishene	82	1	6
Port Arthur	318	1	6
St. Thomas	568	4	16
Smiths Falls	231	· _	6
Toronto	595	14	18
Whitby	528	6	18
Woodstock	39	1	6
Cedar Springs	N.S.	2	6
Toronto Psych. Hospita	1 303	3	4
Thistletown	34	4	5
Children's Psychiatric			
Research Inst. London	410	_2	6
	6,099	65	183
		_	

### Notes:

Sources of Information: Highlights on the Mental Hospital Problem in Ontario 1961; Directory of Social Workers employed in the Provincial Mental Health Services, 1961.

\*According to A.P.A. standards, 1 social worker is needed for each 80 new admissions per year, 1 to 60 patients on convalescent or family care and 1 supervisor to every 5 case workers. As an example, if these standards were to be applied to the Ontario Hospital, Brockville, the minimum staff requirement would be 17 social workers.

366. TABLE I - First Admissions, the Number of Qualified Social Workers
(B) and Estimated Establishment

Provincial Department of Health Outpatient Services:

Ontario Hospital Mental Health Clinics	First Admissions	# of Social Workers	Estimated Establishment
Brockville (T)	413	1	3 *
Hamilton (T)	489	-	3
Kingston (T)	466	-	3
Kitchener	580	. 2	3
London	574	-	3
New Toronto	210	2	3
North Bay	162	-	2
Ottawa	394	4	4
Peterborough	295	- `	3
Port Arthur (T)	702	1	3
St. Catharines	816	1	3
St. Thomas	568	1	3
Sarnia	128	0	2
Toronto	348	2	3
T. P. H. (Adult)	797	4	4
Whitby (T)	198	1	2
Windsor	692	1	3
Woodstock	59	1	2
Day Care Centres:			
Cobourg	230	1	3
Т. Р. Н.	88	1	2
Special Service:			
E. York & Leaside Chile	d		
Guidance Clinic	59	1	2
T. P. H. Child Guid. Clin	ic 177	5	5
T.P.H. Forensic Clinic		4	4
	8,688	33	68
		_	_

#### Notes:

T = Travelling Clinic

Source of Information:

5th Annual Statistical Summary of Community Mental Health Services in Ontario 1960.

<sup>\*</sup>The minimum staff required at Brockville, using the A.P.A. standard of 1 - 60 would be 6 social workers.

367. TABLE I - First Admissions, the Number of Qualified Social (C) Workers and Estimated Establishment

Community In-Patient Services, Psychiatric Units in General Hospitals, etc.:

Psychiatric	First	# of Social	Estimated
Unit	Admissions	Workers_	Establishment
Brantford General	193	-	*4
Kingston General	122	1	*2
London St. Joseph's	327	1	3
London Victoria	369	1	2
Ottawa Civic	55	2	*1
Ottawa General	343	2	*6
St. Catharines General	187	**	*3
Sudbury General	295	1	*6
Toronto General	255	-	*5
Toronto St. Michael's	225	-	*4
Toronto Western	240	-	*5
Toronto Women's Colle	ge 115	-	*2
Windsor Metropolitan	321	-	*6
Wellesley	392	-	*8
Alcoholic Research			
Foundation	-	-	-
Kingston Sunnyside	10	1	1
Warrendale	6	10	10
Total:-	3,455	19	68
		=	==

Notes:

Sources:-

Sixth Annual Statistical Summary Psychiatric Units of Public Hospitals in Ontario, 1960

Other information was obtained informally and is not to be regarded as official.

<sup>\*</sup>Estimated according to A.P.A. Standards for Hospitals and Clinics at approximately 1 social worker per 50 admissions.

TABLE I - First Admissions, the Number of Qualified Social Workers 368. and Estimated Establishment

Community Outpatient Services, Clinics, etc.:

Community O.P. Clinics	First Admissions	# of Social Workers	Estimated Establishment
Hamilton	473	1	7*
Toronto M. H. Clinic	339	4	4
T.G.H. Adults	301	_	5*
T.G.H. Sick Children	1,231	3	3
York Twp. C.G.C.	79	2	2
York County	_	-	1
Toronto Child. Adjust.	. 460	4	4
Toronto Western	1,131	_	18*
St. Michael's	N.S.8	-	_
West End Creche	20	1	1
Ottawa General C.G.C	248	1	3
Toronto J & F Court	425	_5	_5
Total:-	4,707	21	53
Note:		=	=

Where the information was not available from published sources it was obtained informally and is not to be regarded as official.

#### 369. TABLE I - Summary (E)

Hospital	No. of Social Workers Emp		
Ontario Hospitals	64	171	107
Hospital Schools	3	18	15
Mental Health Clinic	33	<b>6</b> 8	35
Community In-patient			
Services	19	68	49
Community Outpatient			
Services	21	_53	32
Total:-	138	378	238
	=	=	===

<sup>\*</sup>The minimum staff required at Hamilton Clinic, using the A.P.A. Standard of 1-60 would be 7 social workers, etc.

# 370. TABLE II - Social Work - Comparative Salaries at September 1961

	37.		Caseworl	kers	S	uperviso	ors	
	No. Emp.	<u>B. A.</u>	<u>B.S.W</u> .	M.S.W.	s.w.III	<u>IV</u> <u>V</u>	<u>v</u>	
Met. Child Aid	200	3,504- 4,164	4, 164- 4, 992	4,992- 6,000	6,000 7,200	6,552 7,872	-	-
Catholic Child, Aid	95	3,504- 4,164	4, 164- 4, 992	4,992- 6,000	6,000 7,200	6,552 7,872	-	-
Federal Governmen	nt	-	4,200- 4,920	5,160- 5,880	5,700- 6,420	6, 180- 6, 900		7,500 8,700
Ontario De of Health	pt. 130		4,200 5,000	5,000- 6,000	5,500 6,600	6,000 7,200		5,750- 7,800 S.W.A.

# Executive Staff - No. of Positions and Salary Range

Metro. Children's Aid	10 at \$7,500 - \$10,000
Catholic Children's Aid	4 at \$7,500 - \$10,000
Federal Government	NONE
Ontario Dept. of Health	NONE

371. TABLE III - Showing the Number of Students Graduating with M.S.W. in 1961

# Toronto School of Social Work:

- 23 Graduated having successfully completed two years' study.
- 10 Accepted employment in psychiatric settings, of these 6 were bursary students returning service.

# St. Patrick's College, Ottawa:

- 16 Graduated having successfully completed two years' study.
- 5 Accepted employment in psychiatric settings, of these one was a bursary student returning service.

372. TABLE IV - Ontario Mental Health Bursary Holders and Number at Present Employed in the Mental Health Field in Ontario

Year	Bursary Holders	No. in Mental Health
-1950-51	18	4
1952-53	6	1
1953-54	4	3
1954-55	4	3
1955-56	5	2
1956-57	2	0
1957-58	3	1
1958-59	5	3
1959-60	6	5
1960-61	_9	_8
Total:-	62 (trained)	30 (now employed)

373. Requirements for Occupational Therapists and Physiotherapists in

Ontario Psychiatric Facilities (prepared by Miss Margaret Langley, O. T. Reg)

(Appendix 11)

The estimated number of qualified occupational therapists as of December 20, 1961, is 131, of whom 50 are employed in psychiatric facilities. The present total enrolment of student occupational therapists in Ontario is 257 (see Supplementary Table #11a). All of the 153 working occupational therapy assistants are employed in Ontario Hospitals; and there are 17 trainees presently enrolled (see Table #1e).

- 374. Observations about the present severe shortage of occupational therapists employed in psychiatric facilities in Ontario include major causes and recommendations.
- 375. <u>Major Causes include</u>: The combining of the course in occupational therapy with the course of physiotherapy at the University of Toronto as of September 1951.
- 376. The obscure image of the aims and purposes of occupational therapy

per se; and of the roles and functions of the qualified occupational therapist.

- 377. Lack of a degree course in occupational therapy, and the resultant inaccessibility to higher education essential for administrative and teaching roles.
- 378. Inadequate preparation of psychiatrists, both practising and teaching, with regard to appropriate usage of occupational therapy.
- 379. Obscure and limited overall policies regarding comprehensive treatment and rehabilitation of the mentally disabled and present lack of professional personnel and services generally.

### 380. Recommendations include:

THAT a request be made that a separate course in occupational therapy be established at the University of Toronto, because the present combined training is inadequate in both the preparation and the output of occupational therapists for psychiatric needs.

381. THAT occupational therapy roles and functions be known and understood essentially as follows:

The purposes of occupational therapy are restoration of function, maintenance of existing healthy function, assessment and diagnostic assistance. The roles of the occupational therapist are co-ordination, administration, treatment, teaching and research.

382. THAT personnel policies be established with regard to occupational therapy which provide appropriate class definitions, categories and salary schedules commensurate with the required qualifications and job responsibilities.

- 383. THAT comprehensive professional education and training of occupational therapists be established which provides levels of qualification related to the requirements of the whole range of responsibility, from the basic entry level of clinical practice up to and including the most responsible administrative and teaching positions.
- 384. THAT adequate preparation of psychiatrists at both the undergraduate and postgraduate levels be requested with regard to the appropriate usage of occupational therapy; and of psychiatrists teaching in courses of occupational therapy.
- 385. THAT the concepts of treatment and rehabilitation of the mentally disabled be clarified; and that a realistic policy framework be established in which occupational therapy is effectively related to all other disciplines concerned.
- 386. Further explanation of these causes and recommendations is provided in the accompanying appendices and tables. The appendices are arranged topically in this order:
  - 1. Occupational Therapy Roles and Functions.
  - Ratio of Occupational Therapists to Psychiatric Beds. and
  - Increasing the Supply of Occupational Therapists to meet Psychiatric Needs.
  - 4. The Education and training in Occupational Therapy.
- 387. SUMMARY TABLE I indicates the present numbers of personnel employed in occupational therapy and related activity programs in psychiatric facilities in Ontario. These numbers are based on the replies received as of December 20, 1961, to a questionnaire sent to the various superintendents of the 20 Ontario Hospitals of the Mental

Health Branch of the Ontario Department of Health, the 3 private mental hospitals of 20 or more beds, and the directors of the 17 psychiatric units in general hospitals. In this table, employees are grouped according to those with recognized specific professional and sub-professional qualifications in occupational therapy; and those with related professional, technical and other qualifications.

- 388. Supplementary tables I(a) and I(b) show the distribution, and lacks of occupational therapists and occupational therapy assistants in the Ontario Mental Hospital Service and the private mental hospitals and psychiatric units mentioned above. And similarly tables I(c) and I(d) present the picture with regard to the other people employed who have related professional, technical and other qualifications. Table I(e) presents in detail the employment trends with regard to occupational therapy assistants.
- SUMMARY TABLE II points out the trend of the diminishing numbers of occupational therapists entering employment in the Ontario Hospital Service. This picture pertains through the psychiatric facilities in Ontario. Table II(a) shows the correlation of this trend with the combining of the occupational therapy course with the physiotherapy course by the University of Toronto commencing in September 1951.

  Tables II(b) and II(c) show the trends with regard to the other sources of occupational therapists employed in the Ontario Hospitals including the special course in occupational therapy at 47 Queen's Crescent, Kingston, McGill University and occupational therapists trained in other countries.
- 390. <u>SUMMARY TABLE III</u> indicates goals with regard to establishments of occupational therapists for the various Ontario Hospitals; trends in

achievement of these goals; and the suggested distribution based on a required overall ratio of one occupational therapist to one hundred patients.

- 391. Appendix No. 1, re: Occupational Therapy Roles and Functions:

  The title of occupational therapist applies only to a person who has successfully completed a recognised course in occupational therapy and all the supervised clinical practice required either by the course or by the official national professional body of occupational therapists.
- 392. The roles of the occupational therapist include co-ordination, administration, treatment and teaching. The purpose of occupational therapy is first and foremost restoration of function physical and mental, secondary and concurrent purposes include maintenance and improvement of existing health function, exploration of latent abilities, change detection, diagnostic assistance, assessment, teaching and research for the purposes of treatment and rehabilitation. The characteristic means by which these purposes are achieved are activities work, training, and recreation interpersonal relationships, and the environment. And the method includes modification of these means according to patient needs progressively toward rehabilitation and patient participation.
- 393. Appendix No. II, Re: Ratio of Occupational Therapists to Psychiatric Beds:

  The recommended ratio of one occupational therapists per every 100

  beds of overall psychiatric facilities is the basic requirement to provide

  essential occupational therapy services for psychiatry. This is regarded

  as a relatively enduring ratio with a possibility of some increase, and

  changes of emphasis compatible with changing concepts and conditions.

- 394. This overall ratio will provide establishments of occupational therapists appropriate to the various professional roles of co-ordination, administration, teaching and clinical practice, to the kinds of psychiatric facility and treatment requirements. For instance, in treatment a higher ratio will be indicated with regard to schizophrenic patients than to geriatric and mentally retarded patients. Higher ratios will also be required in centres which combine treatment with teaching and training.
- is accepted as desirable and necessary in providing for the overall activity requirements of the patients, these other people include employees and volunteers with related professional or teaching qualifications, and trained aides. The services rendered by these people is essentially ancillary to the services of occupational therapists. The use of such people is a trend which is growing rapidly in numbers and scope of services rendered. Adjustment in numbers of people required to provide activities may be met through these people, and in this way the ratio of occupational therapists can remain relatively constant.
- assistants in 1953. In principle the training and the employment of these workers when supervised by occupational therapists is basically sound.

  However, Table No. I(a) shows conflicting trends in the decreasing number of occupational therapists and an increasing number of occupational therapy assistants, and an increasing number of hospitals where the latter are working with no supervision by occupational

therapists. This situation is contributing progressively to diminishing quality in occupational therapy services and to a negative picture of occupational therapy.

397. Appendix No. III - Re: Increasing the Supply of Occupational Therapists to Meet Psychiatric Needs:

The recommendations to increase the supply of occupational therapists to meet psychiatric needs is based on extreme and long standing shortages. Tables No. II and II (a) show a persistent trend of diminishing numbers of such therapists seeking psychiatric employment. A companion trend is the resultant lowering in quality and quantity of professional occupational therapy services which can be related vocationally by people considering this work. These and other strongly adverse trends are combining with such force that occupational therapy in psychiatry as a professional career is being extinguished as illustrated in Table No. II. One of the most pertinent casual factors of the diminishing numbers has been the combining of the courses in Physical Therapy and Occupational Therapy by the University of Toronto in 1953. Previous to this time the University of Toronto was the sole source of occupational therapists entering psychiatric employment in Ontario; and an average of 20% of the total graduates entered the Ontario Mental Hospital Services alone.

398. Table No. II shows the employment trends and the rapidly decreasing number of graduates seeking psychiatric employment since the establishment of combined training in physical and occupational therapy in 1953 by the University of Toronto. Only 5 people from a total of 151 graduates in the past three years have sought such employment.

Table No. II(b) shows that schools of occupational therapy outside of Ontario have provided this service with a negligible number of staff.

Table No. II(b) also shows the trend with regard to foreign trained occupational therapists in this field. This group provide questionable relief in that these people are esentially transients and their contribution is personally oriented and short term employment.

399. Appendix No. IV - Re: The Education and Training in Occupational Therapy:

The following factors in education and training have an important bearing

on the present serious shortages of occupational therapists in psychiatric

facilities in Ontario:

The terminal nature of the present available courses in occupational therapy which are undergraduate diploma courses.

The lack of a degree course in occupational therapy with the resultant inaccessibility to postgraduate university education required for responsible administrative and teaching positions.

The combining of the occupational therapy course at the University of Toronto with another course (physiotherapy) which in effect, does not provide occupational therapists for psychiatric employment. Prior to this the Occupational Therapy Course at the University of Toronto was a staple source for psychiatric needs.

The discontinuance of compulsory psychiatric interning from 1951 to 1961.

- 400. The basic education and training of occupational therapists in Canada is provided in recognised diploma courses at the university level, and in required interning. The length of the required courses is from two to three years depending on the entrance requirements of the particular courses. The amount of required interning ranges from six to ten months and is also related to the particular course.
- 401. It is the combination of scientific and technical education and training that denotes the special and unique contribution of occupational therapy

in treatment and rehabilitation. The present diploma courses and the requisite clinical training provide the minimum qualifications for the entry level of employment as an occupational therapist which is essentially in the area of clinical practice.

- degree is available. This eliminates access by occupational therapists to postgraduate university education and qualifications, essential for their higher professional roles of co-ordination, administration, supervision, teaching and research. This limitation is a vital negative factor in the recruitment of occupational therapists. Added to this is the second negative factor which is the combining of the occupational therapy course with the physiotherapy course at the University of Toronto as of September 1951.
- 403. The third is the request in 1951 that the Canadian Association of
  Occupational Therapists withdraw all its requirements of interning
  beyond the academic year including the established two months
  compulsory interning in psychiatry. This was contrary to the judgment
  and advice of the National Association of Occupational Therapists. At
  this time this association managed to retain one two-month period of
  interning elective in any one of the major diagnostic areas. This was
  later increased to two periods of two months and in 1961 an additional
  two-month psychiatric internship was re-established as a requirement
  for the registration of qualified occupational therapists.
- 404. Experience in the intervening years has been as anticipated diminishing numbers of University of Toronto graduates entering occupational therapy in general and psychiatric occupational therapy in particular as shown in Table II(a). These graduates attribute this to inadequate training

and orientation. Experienced occupational therapists add to this reason the cumulative and negative results of protracted shortages of qualified personnel.

- of Occupational Therapists took two important steps. The first was the establishment of an advanced standing course in occupational therapy, known as the special course in occupational therapy and is located in Kingston. It is anticipated that this course can become a realistic source of supply in occupational therapy with vigorous recruitment and student bursaries. The second step was the re-establishment of compulsory psychiatric internship in 1959.
- 406. With regard to the training of aides, there is one established course in Ontario, the Occupational Therapy Assistants Course, located at the Ontario Hospital, Kingston. This is a four-month course of training in the area of psychiatry and at the assistant level only. It is provided by the Mental Health Branch of the Ontario Department of Health.
- workers is basically sound. Table No. I(e) shows the number of such employees who have been trained for and are working in the Ontario Mental Hospital Service. Table No. I(a) indicates the existing adversely high ratio of assistants to therapists; and also the growing number of situations in which these assistants are employed without supervision. This produces a distorted and impoverished image of occupational therapy which seriously affects the number of professional students who proceed to psychiatric employment.

408. SUMMARY TABLE I - Re: Personnel employed in Occupational Therapy and Related Activity Programs in Psychiatric Facilities in Ontario, from replies received up to December 20, 1961, to a survey which included the 20 hospitals of the Ontario Mental Health Branch, the 3 private mental hospitals with over 20 beds and the 17 psychiatric units in general hospitals.

Employees and Qualifications	Ontario Hospital Services 21, 131 pts.	Private Mental Hospitals 303 pts.	Psychiatric Units in Gen. Hospitals 513 patients	Total 21,947 patients
Employees with recog specific qualifications occupational therapy:				
Occupational Therapists - Occupational Therapist Assistants -	<b>3</b> 8*	3	13	54*
	152	weins		<u>152</u>
	190	3	13	206
		=	=	
Other employees with related professional technical or other qualifications:				
Professional -	7	1	12	20
Technical - Others (incl. Nurse	22	1	0	23
Aïdes & Attendants -	40	4	_4	48
	69	6	16	91
	-	=	=	
TOTAL:	259	9	29	297*
*Includes:	3 occupational		employed in tea	ching,

('pts.' denotes patients)

<sup>1</sup> in administration, and

<sup>3</sup> part-time in treatment

409. SUPPLEMENTARY TABLE I at - Re: Personnel with recognized specific qualifications in occupational therapy employed in psychiatric facilities in Ontario estimated as of December 20, 1961.

Ontario Provincial Mental Hospital Services:

Ontarto	Number of	Cooupational	Occ. Therapy	TOTAL
Hospitals	Patients	Therapists	Assistants	
Aurora	238	-	1	1
Brockville	1,439	3(inel. 2p)	17	20 (incl. 2
				p)
Cedar Springs	250	-	-	400
Cobourg	499	~	6	6
Hamilton	1,630	2	10(inc. 1p)	12(inc.lp)
Kingston	1,449	2	15	17
London	1,416	2	11	13
New Toronto	991	6(inc. lp)	8	14(inc. lp)
North Bay	796	-	6	6
Orillia	2,633	-	6	6
Penetanguishene	676	-	2	2
Port Arthur	677	1	7	8
St. Thomas	1,991	2	22	24
Smiths Falls	2,269	1	9	10
Toronto	1,255	5	3	8
Whitby	1,484	2	6	8
Woodstock EP Div.	604	1	12	13
Woodstock CP Div.	670	1	12	13
CPR Inst. London	35	-	**	- Nov
Thistletown	54		-	-
Toronto Psychiatric	75	6	_	6
•				
	21, 131			
Employed in Treatm	ent	34 inc. 3p	153 (inc. lp)	187 (inc. *p)
Occupational Therap	y			
Assist. Course		3	1	4
Administration		11	man .	1
TOTAL:		38	154	192
SUMMARY:				
16 Mental Hospitals	15.891	33 inc. 3p	138. inc. lp.	171 inc. 4p)
3 Hospital Schools		1	15	16
2 Spec. Child In.	89	-	-	-
21 Hospitals	21,131	34	153	187

<sup>(&#</sup>x27;p' indicates part-time employee)

410. SUPPLEMENTARY TABLE I(b) - Re: Occupational Therapists employed in psychiatric facilities in Ontario other than the Ontario Provincial Mental Hospital Services.

1.	Private Mental Hospitals and Number of Beds		Occupational Therapists
	Bethseda	93	-
	Dalmeny	40	1
	Homewood	190	_2
		323	3
2.	Psychiatric	No.	Occupational Therapists
	Units	of	presently employed
	Located at-	Beds	December 20, 1961
	Brantford General Hosp.	24	1
	Hamilton General Hosp.	30	1
	Kingston General Hosp.	40	1
	London Victoria Hosp.	52	_
	London St. Joseph Hosp.	33	1
	Ottawa General Hosp.	30	_
	Ottawa Civic Hospital	40	1
	Royal Ottawa San.	30	1
	Peterboro Civic Hosp.	26	1
	St. Catharines Gen. Hosp.	24	-
	Sudbury General Hosp.	30	_
	Toronto Wellesley Hosp.	40	1
	Toronto St. Joseph Hosp.	26	-
	Toronto St. Michael Hosp.	30	1
	Toronto Western Hosp.	38	2
	Toronto Women's College	20	1
	Windsor Metropolitan Hos. (Psychiatric Services provided by the general	30	-
	staff of 3 occupational therapists)		
			_
	Total: 17 Hospitals	543	12
			_
		Total:	15

411. SUPPLEMENTARY TABLE I(c) - Re: Personnel with related professional, technical or other qualifications employed in psychiatric facilities in Ontario, estimated as of December 20, 1961.

Ontario Provincial Mental Hospital Service.

Professional			
Recreation Director:	London	1	
	St. Thomas	_1	2
Artist Teacher:	London	1	
	St. Thomas	_1	2
Psychology-Hospital Indust.:	Kingston	1	1
Teacher PH & E:	Toronto Psychiatr	ic 1	1
Teacher - Academic:	CPR Inst. London	1	1
Nurse:	-	-	
			7
Technical			
Trades Instructor:	Kingston	2	2
Seamstress:OT Cen.:	St. Thomas	1	1
Recreation Supervisor:	Aurora	1	
	Brockville	1	2
School Aide:	Woodstock	2	2
Hairdresser:	Brockville	4	
	London	2	
	Woodstock	4	10
Clerk: Pt. Library:	Brockville	1	
	St. Thomas	1	
	Woodstock	1	3
Clerk: Volunteers:	St. Thomas	1	1
Dance Instructor:		_	
Physical Instructor:	CPR Inst. London	1	1
I hydroat motitions.	Of it mst. London		22
Others - 1. Attendants			
Hospital Industries:	Penetang	2	2
Assist. O.T. Centre:	Brockville	2	
	Kingston	1	
	Orillia	1	
	St. Thomas	1	
	Toronto	1	
	Woodstock	4	10
Recreation Music Assist:	Brockville	6	
	Hamilton	1	
	St. Thomas	4	11
Gardens:	Aurora	2	2
Laundry:	Aurora	2	2
Ladidiy:			
Food Service:	Aurora	3	3
	Aurora Woodstock	3 1	3

2.	Nurse	Aidea
4.	Nurse	Alues

Gen. of O. T. Assist:	-		
Craft Instructor:	St. Thomas	1	1
OT: Hospital Industry:	Hamilton	4	4
Recreation: Music Aid:	Brockville	4	
	St. Thomas	7	11
Recruit: O. T. A. Course:	St. Thomas	3	3
			19

# TOTAL PERSONNEL

Aurora	8
Brockville	18
Hamilton	Ę
Kingston	4
London	4
Orillia	1
Penetanguishene	2
St. Thomas	21
Toronto	1
Woodstock	12
CPR Institute, London	2
Toronto Psychiatric	_1
TOTAL:	79

412. SUPPLEMENTARY TABLE I(d) - Re; Personnel with related professional, technical or other qualifications employed in psychiatric facilities in Ontario, estimated as of December 20, 1961.

Private Mental Hospitals - Psychiatric Units in General Hospitals.

Professional			
Artist: Teacher:	Hamilton	1	
	London St. Joseph	1	
	Ottawa Civic	_1	3
Psychology: Hosp. Industry:	Ottawa Civic	2	2
Nurse:	Bethseda	1	
	Ottawa Civic	1	
	Peterborough	<u>6</u>	8
Technical			
Dance Instructor:	Homewood	1	1
Others - 1. Attendants			
O. T. Centre Assistant:	Bethseda	2	
	Toronto W. C. H.	1	3
2. Nurse Aides			
Gen. O. T. Assistant:	Kingston	1	
	St. Michaels Toronto	1	2
Craft Instructor:	Homewood	1	1
Recreation: Music Aide:	Homewood	1	
	London Victoria	1	_2
			22

## TOTAL PERSONNEL

Bethseda	3
Homewood	3
Hamilton	1
Kingston	1
London Victoria	1
London St. Joseph's	1
Ottawa Civic	4
Peterborough	6
Toronto St. Michael's	1
Toronto Women's College H.	_1
TOTAL:	22

413. SUPPLEMENTARY TABLE I (e) - Re: Employment trends of Occupational Therapy Assistants in the Ontario Hospital Service.

Appointed to Ontario											Presently Emp.
Hospital	1953	'54	'55	'56	'57	158	'59	'60	'61	Total	Dec.20/61
Aurora	_	_	1	_	_	_	_	_		1	1
Brockville	3	3	1	1	3	2	4	5	4	26	17
Cedar Springs	-	-	_	-	_		100	-	-		
Cobourg	-	_	4	-	2	-	2	_	2	10	6
Hamilton	4	6	_	~	_	2	4	_	2	18	10(inc.1p)
Kingston ·	5	2	5	2	3	2	3	1	2	25	15
London	4	3	2	-	2		1	3	2	17	11
New Toronto	4	2	1	1		_	_	2	3	13	8
North Bay	-	_	-	-	_	-	3	1	1	5	6
Orillia	-	-	-	-	-		1	2	4	7	6
Penetang	_	_	_	_	_	_	_	_	2	2	2
Port Arthur	_	1	3	1	1	1	3	1	1	12	7
St. Thomas	4	3	4	1	5	2	6	9	5	39	22
Smiths Falls	5	4	2	no.	-	_	-	2	_	13	9
Toronto	3	2	1	2	_	-	_	_	_	8	3
Whitby	_	-	-	_	6	2	1	3 -	2	14	6
Woodstock	10	8	2	2	1	3	1	3	2	32	24
CPR Inst. London	***	_	_	-	_	_	_	_	-	-	
Thistletown	-	_	_	_	_	_	-	_	_		_
Tor. Psychiatric	_		-	_	_	-	_	_		_	_
OTA Course	-	-	1	101	-	-	-	-	-	1	1
TOTAL:	42 3	4 2	7 1	LO 2	23	14	29	32	32	243	154

The Mental Health Branch of the Ontario Department of Health established in January, 1953, a centralized course, located at the Ontario Hospital, Kingston, to train aides to assist in the occupational therapy services of its hospitals. On successful completion of this course, these people are classified as Occupational Therapy Assistants.

('p' denotes part-time employee)

5. 414. SUMMARY TABLE II - Re: Sources and Employment Trends of Occupational Therapists in the Ontario Hospital Service.

University of Toronto Undergraduate Course leading to a Diploma in Occupational Therapy.

TWO-YEAR COURSE	Total Grads.	Number Approx.		Employed Dec. 20/61
1928 to 1933) 1936 to 1947)	521	142	27	20 (incl. 3p)
THREE-YEAR COURSE				
1949 to 1952	234	56	24	3
THREE-YEAR COURSE Combined Physical and Occupational Therapy				
1953 to 1958	450	42	9	6
1958 to 1961	151	_5	_4_	_5
	1,356	245		34 (incl. 3p)
SPECIAL COURSE,				
Kingston, 1961	. 11	2		2
MCGILL UNIVERSITY 1959 to 1961		2		1
OTHER COUNTRIES				
1951 to 1961		19		_1
				38 (incl. 3p)*

('p' denotes part-time employee)

<sup>\*</sup> includes 3 'p', 3 teaching, and 1 in administration

415. SUPPLEMENTARY TABLE II (a) - Re: Ontario Sources and Employment Trends of Occupational Therapists in the Ontario Provincial Mental Hospital Service.

University of Toronto Undergraduate Course leading to a diploma in Occupational Therapy.

			ntment to losp. Serv.	Presently Employed
	Graduates	No.	%	Dec. 20/61
TWO-YEAR COURSE				
1928	20	13	65	2
1929	17	11	65	1 (incl. 1p)
1930	27	8	30	2
1931	18	5	<b>2</b> 8	2
1932	11	. 6	54	1
1933	13	2	15	1
1936	13	3	<b>23</b> ,	1
1937	16	7	42	1
1938	15	4	27	
1939	21	7	33	-
1940	26	2	s. 8	-
1941	36	3	8.	1
1942	56	4	7	1
1943	30	5	16	-
1944	32	2	6	1
1945	39	8	20	**
1946	84	18	22	1
1947	47	34	32	5 (incl. 2p)
THREE-YEAR COURSE				
1949	102	17	15	1
1950	55	16	29	1
1951	32	14	44	1
1952	45	9	20	-
THREE-YEAR COMBINED				
COURSE in Physical and Occupational Therapy				
1953 1954	74	3	4	-
1955	87	7	8	-
1956	78	9	11	- <del>-</del>
1957	83	10	12	4
1958	69	9	13	-
1959	59	4	7	2
1960	56	2	4	2
1961	48	2	4	2
1961	47	1	2	1
	1,356	245		34
1962	54*			
1963	83*			
1964	95*			
* Dresently annulled				

<sup>\*</sup> Presently enrolled

416. SUPPLEMENTARY TABLE II (b) - Re: Ontario sources and employment trends of Occupational Therapists in the Ontario Provincial Mental Hospital Service.

Canadian Association of Occupational Therapists Special Course in Occupational Therapy, 47 Queen's Crescent, Kingston, Ontario

Year		Appointed to Ont. Hospital Service	Presently Employed December 20, 1961
1961	11	2	2
1962	11*		
1963	14*		

<sup>\*</sup>presently enrolled.

417. SUPPLEMENTARY TABLE II (c) - Re: Sources beyond Ontario and employment trends of Occupational Therapists in the Ontario Provincial Mental Hospital Service.

Source	Appointed to O	ontario Hospital Service	Presently Employed Dec. 20/61
McGill University	$ \begin{array}{cccccccccccccccccccccccccccccccccccc$		_1_1

Other Countries:

	England	Scotland	U.S.A.	Australia	S. Afric	a Total	
1951	1	_	_	~		1	
1953	-	-	1	and to	***	1	
1954	2	_	_	-	-	2	
1955	3	_	_	2	400	5	
1956	3	-	***	1	-	4	
1957	-	-	***	1	-	1	
1958	1	-		***	-	1	1
1959	3	2	-	2		7	
1960	4	-		-	1	5	
1961	2			-	-	2	
	19	2	1	6	1	29	1
							2

418. SUMMARY TABLE III - Re: Employment trends and goals regarding Occupational Therapists.

## EMPLOYMENT TRENDS -

		<u>H1</u>	GHES	T Present h Staff	G	OALS	Dec. 20/61 Suggested Dis- tribution based or overall ratio		
	1045	Hosp.		p. Dec. 20,		t in		to 100 pts.	
	1945	1950	Eve	r 1961	14	6 '49	O. T. 's	PTS.	
Aurora	***	edit.	_	_		_	2	267	
Brockville	1	2	6	3(inc. 3p)	4	6	16	1,448	
Cedar Springs				o(.mo. op)	-	. 0	6	301	
							U	(900)	
Cobourg	0	1	1	_	2	3	4	506	
Hamilton	2	6	7	2	6		18	1,646	
Kingston	3	4	7	2	6		16	1, 465	
Langstaff		-	_	_	_		_	1, 100	
London	3	7	7	2	6		16	1,416	
New Toronto	2	7	7	6(inc. lp)	6		12	768	
North Bay		_	2	-	_	1	10	801	
Orillia	0	non.	_	_	3	6	. 8	2,628	
Penetang	1	-	2	_	2	3	10	679	
Port Arthur*	_	_	2	2	_	-	10	668	
							10	(272)	
Fort William	1	_	_		_	_	_	(212)	
St. Thomas	_	7	7	2	6	10	22	1,989	
Smiths Falls	-	-	1	_	_	6	8	2,299	
Toronto	4	7	7	5	6	10	15	1,251	
Whitby	1	4	7	2	6	10	16	1, 497	
Woodstock	2	6	6	2	6	10	14	1, 277	
CPR Inst. Lon.	_	-	-		_	_	3	30	
Thistletown	-	-	_	_	_	_	3	62	
Tor. Psych.	2	5	7	6	4	6	9	75	
Goderich	-	_	~	_	_	_	3	300	
Owen Sound	_	-	and .	_	_	400	3	300	
Palmerston		_	ndo	_	_	-	3	300	
	22	56		34	63	110	227	23, 145	
O. T. A. C.			4	3					
Admin.		1	1	1		-	3	-	
· austitii.			1	1	1	1	1		
TOTAL	22	57		38(inc. 4p)	64	111	231	23,145	

<sup>\*</sup>adding 900 & 272

<sup>(&#</sup>x27;p' denotes part-time employee)

419. Economics re Psychiatry (prepared by William R. Mitchell, M.D., FRCP(C) 
M. Alison Mitchell, M.A. ) (Appendix 12)

I

This is primarily concerned with the economics of mental illness in recent years. The Royal Commission's areas of enquiry are:

- a) A present estimate of the cost of mental illness.
- b) A future estimate of the cost of mental illness and the cost of training personnel.
- Proposals as to the way in which increased financing will be paid or should be paid,
- the committee decides to offer as proposals for the future. This projected cost will be easily ascertained by percentage increments which combine the committee's proposals with population increases.

  The question of financing was taken care of by the agreement reached in our meetings. This agreement was to the effect that we wish to be financed by the same commission, or mechanisms, that finance the so-called "physical" disabilities, without any differentiation whatsoever.
- 421. As anyone who has examined this area knows, attempts to evaluate the economics of mental illness depend upon a knowledge of its epidemiology, the availability of good accounting, and the degree to which this accounting has a statistical value. All of these are in a poor state in Canada, but we do not fare as badly as the United States of America.

  We fall short of countries where medicine is under a socialized government, where "costing" is both central and standardized.
- 422. Nonetheless, of all the provinces, Ontario's published statistics are the best, but there is precious little competition from other provinces.

- The Dominion Bureau of Statistics is caught in the position of presenting the lowest common denominator in reporting.
- 423. It will be clear, then, that this draft is yet another attempt to make

  the best of a bad situation and it is hoped that the probable, or possible,

  errors will be made sufficiently clear.
- 424. The general idea of "cost" includes operating and capital costs.

  Initially, at least, "loss to society" costs are excluded and we find it impossible to estimate the cost of training personnel.
- 425. A psychiatric illness is whatever patients currently seen by physicians have when the conclusion is "mental illness" (per se) as the major disability.
- 426. All figures are for Canada. Provincial figures (Ontario) are 30-40% of the whole Canadian estimate. It has not been considered too valuable to reduce this to a provincial level alone for the costing figures are too frequently analogies from Great Britain or the United States of America to Canada, or from a provincial level to a federal level. All estimates have been adjusted to nearby round figures.

Π

- 427. The operating and capital costs for mental illness are:
  - Government expenditure for mental illness institutions is 100 million dollars per year. This is a round figure taken from the Dominion Bureau of Statistics 1959 and is for all of Canada.
- 428. 2) Government capital expenditures for institutions for mental illness is 25 million dollars per year. This estimate is derived from the Economic and Social Survey, Ontario, Ontario Department of Economics, 1961. This is currected to a Federal level.

- 429. 3) General hospital psychiatric beds cost 10 million dollars per

  year for Canada. This is taken from Hospital Care in Canada, Health
  and Welfare, Ottawa, March 1960 (figures for 1958.) Psychiatric beds
  are not separated here but Health and Welfare, Ottawa, (personal
  communications) suggests that the general hospital bed "cost" is
  representative, that is, 18-20 dollars per day.
- 430. 4) The medical cost of undeclared illness is estimated to be 55

  million dollars per year. In Economics of Mental Illness by R. Fein,

  Basic Books, 1958, the percentage of psychiatric patients attending
  general practitioners in the United States of America has been variously
  declared to be from 10% to 50%. Because of this spread, 25% is chosen
  here and is below the arithmetic mean. As well, private psychiatric
  treatment is not included in this report and is likely a considerable
  figure. 25% of the national medical income is 50 million dollars per
  year. Another 5 million dollars is added for the estimated cost of
  medication given outside hospital. For the Province of Ontario, less
  than one-tenth of overall expenditure on mental illness is spent on
  medication.
- as opposed to the cost of declared mental illness, is 150 million dollars

  per year. This estimate is based on the British experience (personal communication, Professor A. B. Stokes, Toronto) where 3% of the labour force was found to contribute less than it was paid and an attempt to lower this to 2% was impossible. They found that this drain was not due solely to the physically disabled who oftentimes were found to be more than averagely productive. Any given organization is oriented as a chronically supporting institution to this small

psychiatrically ill number. More properly this group should be the responsibility of organized psychiatry. Canada's labour force is 6 million (those employed only) with an income of 20 billion dollars per year. Three percent of this is 600 million dollars.

- 432. Conservatively, an arbitrary statement can be made that the drain produced by the psychiatrically disabled in this group is again (cf. point 4) 25% of this 3%. This amounts to 150 million dollars per year.

  Rehabilitation measures, even as they exist now, would swell this estimate.
- 433. Thus far, the total cost of mental illness in Canada in recent years is:

  340 million dollars per year.
- Wales where 1.6% to 1.9% of the Gross National Product is used for psychiatric care. (Product here refers to the total output of goods and services.) Taking this figure to Canada, our costs might now be:

  575 to 685 million dollars per year. (Cost of the National Health Service, Abel-Smith and Titmuss, Cambridge University Press 1956.) It will be clear that our estimates are not inflated and the difference between these possible expenditures as ratios of the G.N.P. and the figure of 340 million dollars is likely to reflect the poor "costing" in Canada.
- 435. 7) On October 17, 1961, the Wall Street Journal printed a frontpage article which said that the loss to society of those who were ill,
  of those who attended them and of the training of the whole group would
  allow an estimated doubling in actual costs. Were this allowed, our
  national cost would be:

680 million dollars per year.

- 436. 8) Whatever the committee might think of 340 million dollars per year, it can always be described as conservative. Ontario's share of this, using points 1, 2, 3, 4 and 5, is about:

  136 million dollars per year.
- 437. Social loss, i.e. total cost, is:

  272 million dollars per year for Ontario.

# PLAN MEDICAL WELFARE 1957 - 1961

o. Dorticinanta Funds. Accounts. Payments to Doctors. Operational Costs. - Based on 12 months! experience Monthly Av

Monthly Averages: Participants, Funds, Accounts, Fayments to Loctors, Operational Costs - Based on 12 months experience	ids, Accounts, Fay	ments to Doctor	s, Operational C	oses - eased on	12 monuis experience
	1957	1958	1959	1960	1961
INCOME					
Participants Income per Participant	160,640	191,367	\$ 1.25**	209,162	\$ 1.25
Receipts from Ontario Department of Public Welfare	\$ 168,672.00	\$ 200,934.00	\$ 222,154.00	\$ 261,290.00	\$ 279,615.00
MEDICAL SERVICES					
Accounts Submitted	33, 354	37,442	40,039	42,274	45,496
Office Calls	31,151	35,786	38,567	42,503	46,994
Home Calls	28,524	28,975	28, 957	28,428	27,315
Special Services	4,656	5,617	5,962	6,117	6,744
Mileage	\$ 7,155.00	\$ 6,695.00	\$ 6,302.00	\$ 6,032.00	\$ 5,694.00
Value of Services (Total Rendered					
Fee)*	\$ 252,619.00	\$ 281,960.00	\$ 297,503.00	\$ 312,321.00	330,6
Value of Services per Participant	\$ 1.57	\$ 1.47	\$ 1.47	\$ 1.49	\$ 1.48
Amount Paid to Doctors	\$ 173,233.00	\$ 184,724.00	\$ 203,605.00	\$ 246,047.00	\$ 261,240.00
Amount Paid per Participant	\$ 1.08	\$ 0.97	\$ 1.01	\$ 1.18	\$ 1.17
Payment to Doctors per Dollar of					
Rendered Fee	\$ 0.69	\$ 0.66	\$ 0.68	\$ 0.79	\$ 0.78
ADMINISTRATION					
Administration Costs	\$ 11,164.00	\$ 12,710.00	\$ 13,629.00	\$ 14,434.00	\$ 16,426.00
Administration Cost in relation to Income	6.6%	6.3%	6.1%	5.5%	5.9%

MEDICAL WELFARE PLAN

\*Rendered Fee: 1955

Schedule with Amendments to 1958

\*\*9 months at 1.05

MEDICAL WELFARE PLAN STATISTICS

January to December 1961, inclusive - Projected on basis of 1962 Fee Schedule

Category	Participa Male Fe		Numi	per of Ac	counts F	Office M.	Calls F	Home M	e Calls		Speci: Servi	ces	Rendered Fe	e <u>F</u>	Incidence per 1 M Participants M F	No. of Services per 1 M Participants M F	1 M
Old Age Assistance																	
Age 65-69	71,558	163,843	H&O* SS**	17,257 1,347	39,296 3,087	23,236	49,733	9,958	21,968	2,	041	5,063	131,571.75 11,617.00 143,188.75	284,798.75 29,593.25 314,392.00	260.0 258.7	492.4 468.5	2,001.02 1,918.86
Old Age Security																	
Age 70-74	80,106	189,615	H&O SS	20,194 1,678	47,799 3,458	25,209	54,542	13,197	33,937	2,	535	5,268	157,987.50 14,805.50 172,793.00	373,964.00 30,614.50 404,578.50	273.0 270.3	511.1 494.4	2,157.05 2,133.68
Age 75-79	78,757	177,787	H&O SS	19,558 2,018	44,148 3,528	21,546	43,550	16,774	37,159	3,	623	5,387	164, 978. 50 15, 213. 00 180, 191. 50	352, 244, 00 26, 018, 50 378, 262, 50	274.0 268.2	532.6 484.3	2,287.94 2,127.62
Age 80-84	59,273	126,544	H&O SS	14,685 1,403	31,170 1,930	16,443	22,707	13,598	40,789	2,	732	3, 334	130,793.50 9,507.75 140,301.25	305, 231.00 14, 231.75 319, 462.75	271.4 261.6	552.9 528.1	2,367.03 2,524.52
Age 85-89	25,536	53,777	H&O SS	6,378 650	13,490 914	5,324	7,921	6,369	20,856	1,	142	1,351	52,620.00 4,920.50 57,540.50	139,766.00 6,087.75 145,853.75	<b>275.2 267.</b> 8	502.6 560.2	2,253.30 2,712.20
Age 90-94	13,629	24,235	H&O SS	3,280 181	5,841 412	1,848	1,682	4,977	10,976		205	708	32,998.00 2,158.25 35,156.25	64,927.00 2,782.00 67,709.00	253.9 258.0	515.8 551.5	2,579.52 2,793.85
Age 95 and over	1,947	3,806	H&O SS	486 49	947 97	381	40	912	1,591		207	144	6,428.00 450.75 6,878.75	8,053.50 225,50 8,279.00	274.8 274.3	770.4 466.4	3,533.00 2,175.25
	330,806	739,607		89, 164	196,117	93,987	180,175	65,785	167,276	12,	485	21,255	736,050.00	1,638,537.50	269.5 265.2	520.7 498.5	2,225.02 2,215.42
	550,000	100,001		00,101												V	
Blind	1	6,826	H&O SS		659 247	;	3,150	1,633		389		389	19,263.00 2,139.50 21,402.50		172.7	307.4	1,271.99
Mothers' Allowance	42	2,966	H&O SS		239 615	6	5,567	10	6,028		8,	799	51,	103.50 697.75 801.25	129.7	213.7	855.39
General Welfare As (Relief)		6,096	H&O SS	142, 27,		194	4,501	5:	1,675		34,	059		881.50 249.75 131.25	160.7	265.3	1,114.61
Disabled Persons	15	4,799	H&O SS		312 526	4	3,089	2	5,149	3,976		976	277,589.50 22,058.50 299,648.00		238.0	466.5	1,935.72
Rehabilitation		2,167	H&O SS		271 57		473		79	114		114		050.00 961,50 011.50	151.4	307.3	1,389.71
	1.05	2,854		264.	591	30	6,780	9-	4,564		47,	337	1,862,994.50		160.1	271.5	1,127.14
	1,65	2,002		204,	A 1	50							4,237	582.00			
								А	dd Render	ed M	ileag	e		330.75			
	*H&O - Home and Office Total Ret				otal Rende												
**SS - Special Services																	

#### COMMITTEE ON PUBLIC HEALTH

## 1. Report on Activities for Session 1961 - 1962

This is a report of the Committee on Public Health to demonstrate activities of a committee of the Association. The chairman of the committee is a paediatrician, and the other members represent the profession throughout Ontario. These consist of general practitioners, obstetricians and a medical officer of health who is the director of a health unit. In addition, one of the general practitioners has had experience as a full-time medical officer of health, and another general practitioner deputizes as a part-time officer. These physicians were chosen as members of the committee in view of their particular interest and experience in those aspects of the practice of medicine which would be under study within the terms of reference of this committee for this year.

#### 2. The terms of reference are:

- To study and make recommendations regarding the responsibilities of the medical profession in matters of public health;
- To develop and recommend policies and practices
   designed to further integrate the practice of medicine
   and the public health program;
- 3) To recommend legislation designed to improve and/or safeguard the public health;
- 4) To review such public health legislation as may be in effect and to make such recommendations in this regard

## ROYAL COMMISSION ON HEALTH SERVICES

Public Hearings, Toronto, May 1962

Appearing for the ONTARIO MEDICAL ASSOCIATION (Canadian Medical Association, Ontario Division)

#### Representatives from:

The Executive Committee:-

- R. H. McCreary, M. D., President, Arnprior
- P. Bruce-Lockhart, M.D., President-elect, Sudbury
- W. W. Wigle, M.D., Past-president, Toronto
- R. D. Atkinson, M. D., Chairman of Council, Waterloo
- R. S. Duggan, M.D., Honorary Treasurer, St. Davids

## The Brief Advisory Committee:-

- R. J. M. Galloway, M. D., Chairman, Toronto
- E. H. Botterell, M.D., Toronto
- F. S. Brien, M.D., London
- R. B. Holmes, M.D., Toronto
- S. N. Nathan, M.D., Toronto
- J. Laframboise, M.D., Ottawa

Committees and Sections - which have submissions appended.

and

The Solicitor to the Ontario Medical Association:-

E. L. Haines, Q. C.

The General Secretary:-

Glenn Sawyer, M. D.



as the committee may deem advisable;

5) To study and make recommendations regarding any items referred by Council and/or the Board of Directors.

#### 3. Shortage of Personnel

The committee was informed at an early date that its advice would be sought on any matters which would come within the terms of reference of the Royal Commission on Health Services. The committee agreed that there is a shortage of personnel in the field of public health which involves, primarily, the availability of nurses and sanitary inspectors for public health units.

#### 4. BCG Vaccination and Miniature Chest X-Ray Surveys

The Committee received a request from a physician who was concerned about some aspects of the Public Hospitals Act, which requires chest x-rays of hospital personnel at stated intervals. The physician was concerned about the effect of radiation on these employees, and questioned whether or not the use of BCG vaccination might reduce the need for such frequent x-rays. The committee sought advice from experts in the field of tuberculosis prevention and specialists in radiology. With the information obtained from these sources, the committee considers there is no reason to advocate a mass BCG vaccination program in Ontario at the present time because the incidence of tuberculosis is not high enough to warrant this method of immunization, and the present case-finding program appears to be improving in efficiency. At the same time the committee believes that the shorter hospital period for the treatment of tuberculosis does not

warrant apathy on the part of the public with regard to the seriousness of this disease.

The committee has investigated the advisability of continuing mass miniature x-ray surveys for tuberculosis. It was the feeling that the radiation hazards to man can be considered as somatic and genetic. The view is advanced that the somatic hazard to the individual and to posterity is insignificant. If it were abolished in Ontario, the saving in genetically significant irradiation would be equivalent to 15.5 hours of naturally occurring background radiation per annum. This information and the conclusion with regard to BCG vaccination was conveyed to the physician who raised the query.

#### 6. Health Units

The committee studied the development of health units throughout the province and surveyed the branch societies of the Association for opinions on the results of public health programs in areas where there are health units, compared with the public health situation prior to the institution of these health units. In addition the committee wrote to each physician who is in private practice and serves as M.O.H. for his community. These physicians have full-time responsibility for the public health in their area, but usually carry on private practice in addition to their duties as M.O.H. As a result of this survey the committee developed the following conclusions:

- 7. The committee is in favour of health units, and recommends:
  - a) that health units be formed in organized territories

where they do not now exist at such times as the municipalities concerned feel they are required, and can be afforded:

- b) one or more travelling health units are recommended for isolated unorganized territories.
- 8. The committee recognizes the difficulty in financing health units

  even though the provincial department of health shares the cost

  of a health unit on an equal basis with the municipality. It is

  recognized that many communities desire to obtain health unit

  services, but do not proceed with the organization of such units

  because of the direct cost.

## 9. Public Health Act

The committee is aware of the fact that revision of the Public Health Act in Ontario is contemplated. Discussions were held with representatives from the Ontario Department of Health. The committee requested information on proposed changes in the Act before legislation reaches the stage where the advice of the Ontario Medical Association would be ineffective. Discussions included a review of the health units in Ontario and the role of the "part-time" medical officer of health.

- The committee recommends that the Public Health Act includea better means of remuneration for medical officers of healthwho are on a part-time basis.
- 11. The committee recommends that in the selection of members of local boards of health that representation be arranged from the local medical and dental societies.

#### 12. Fluoridation

The committee reiterates approval of the principle of fluoridation of public water supplies in the prevention of dental caries. It deplores the apathy and indifference of the general public in relation to this subject. The committee feels a strong educational policy by the Ontario Medical Association is in order.

#### 13. Water Pollution

The committee reviewed the activities of the Ontario Water
Resources Commission and a member of the staff of the O.M.A.
attended a conference sponsored by the O.W.R.C. in November
1961. This information was made available to the committee
along with material supplied by the Department of National
Health and Welfare with reference to the activities of the
International Joint Commission.

- 14. The committee recommends that the O.W.R.C. and the International Joint Commission be commended heartily for their efforts in promotion of clean water and proper sewage disposal.

  It recommends that the medical profession take greater interest in educating the general public that good water and good sanitation have a more important call on the public purse than some other municipal needs.
- 15. It also recommended that there should be greater liaison between the O.W.R.C. and the Ontario Municipal Board so that the functions of the latter do not destroy the principle of the former.
- 16. In order to summarize the information obtained on this subject, the chairman of the committee prepared a document on Water

Pollution which is as follows.

17. Water Pollution
Prepared by the Chairman,
Committee on Public Health,
Ontario Medical Association,

Prior to World War 11, unlimited supplies of naturally clean water seemed to be assured in this province and country. It must be realized that water is one of our natural resources.

There was enough clean water for drinking, domestic, bathing, recreation, industry, agriculture, navigation and other purposes. It is generally accepted that drinking and other domestic needs make the home the highest user of water.

- 18. Coupled with its usefulness is found abuse. Abuse rises in part from thoughlessness and in part from selfish interests. Because Contario in many sections is a sparsely settled province, the effects of abuse are frequently not apparent. This is no longer true in areas where the population has become dense and is coupled with the accelerated growth of industry frequently complex in character.
- 19. Water pollution is now regarded as a health problem by public health authorities in all levels of government. It occurs when excessive amounts of waste, domestic or industrial, are emptied into any body of water which does not have the capacity to assimilate them. The most serious problems are usually connected with low rates of flow in rivers. Many streams which formerly served the communities along their banks are no longer sufficient in quantity or suitable in quality. Other sources of supply must be found, adding great expenses.

- 20. Pollution effects vary with each different use of water. That from human wastes can be of large significance to domestic water supplies and recreational activities, and it can harm aquatic life. Industrial wastes can adversely affect domestic water supplies and fish life. Waste oils can often spoil recreational areas and be responsible for the destruction of wild life. In recent years, the increased use of insecticides and pesticides in agriculture and forestry has dictated the need to study possible pollution effects on streams. Similarly, the extent of problems associated with the discharge of synthetic detergents in municipal wastes has not been fully ascertained. They may be, in part, responsible for luxuriant growths of algae in the receiving waters. Tastes and odors may result from their decomposition.
- 21. It has been estimated that of the earth's total water supply, only one per cent is fresh water. It is in respect to this one per cent of available fresh water, suitable for use by people, plants and animals, that pollution is of greatest significance.
- There are two schools of thought in regard to water usage. One asserts that so long as water treatment methods are capable of producing a safe domestic water, the stream should be used to its maximum capacity for waste disposal purposes. The other favours the riparian rights principle "Under the common law, the riparian owner has the right to full and uninterrupted use of the waters of his stream substantially unmodified in quality or quantity and subject to similar right and usage on the part of other proprietors."

  There are many shades of opinion which favour an in-between policy. The justification usually given for the waste disposal policy

is economics. The basis of requiring clean streams is also economy, of a different kind, but to a greater extent respect for others' rights. Few if any persons would deliberately foul a neighbour's well with body wastes, but provide the same persons with a sewer connection and they will seldom give a second thought to their neighbour in the downstream community. It must be realized that "dilution is not the solution for pollution". It is this public apathy or unconcern which must be overcome if pollution abatement of worthwhile proportions is to be achieved.

- Broadly speaking, the effects of pollution become a matter of general interest only when they are notoriously bad. No one becomes concerned until it directly affects his way of life. The situation arouses public attention when a body of water becomes septic or foul or when fish and wild fowl are destroyed in quantity. At this stage, remedial action becomes unnecessarily costly.
- 24. Because of modern water treatment methods, water-borne epidemics are infrequent although it is quite possible, even probable, that epidemics of non-fatal character go unrecognzied as being water-borne.
- 25. A publication of the World Health Organization contains the following statement:

"When the forces of sanitary deterioration are considered, such as those that accompany increasing population density and industrialization, it becomes evident that the sanitary control of the environment is slipping backward. In spite of all

of a positive nature that W. H. O. and similar agencies have attempted to do, the world is probably in worse sanitary condition now than it was ten years ago. The forces of deterioration have outstripped the forces of betterment."

#### 26. Present and Future Needs

Because of the very heavy demand for water in many industries, there has been an obvious tendency for industry to locate on the larger rivers and lakes whenever a choice of location is possible. Industry attracts or is attracted by urban communities since large numbers of employees are still necessary in spite of the present trend toward automation. Thus future expansion of present manufacturing plants and new industries will greatly increase the need for unpolluted water. Domestic consumption is also increasing rapidly as a result of labour-saving devices in the home. Plans for the future must take these factors into account. Water supplies and waste disposal are closely linked. They both should be dealt with in any program designed to attain the environment desired by all.

- 27. In summary, pollution problems of major significance are already evident in Ontario and will become more common and more severe as industrial and urban development increases. Hence, a more complete knowledge of present conditions coupled with prompt and effective remedial action, are essential for future development and expansion.
- 28. The objectives in pollution control are clear and simple. They call

for clean waters for the use and enjoyment of all. This quantity is measurable by laboratory tests, but a clean stream is a pleasant environment for man, fish, and wild fowl. A sanitary locality is conducive to good health. The contrast between a foulladen water and a clean stream presents a marked difference. Every good neighbourhood must be kept clean.

- 29. A clean water will have a low bacterial count, it will be free of taste, it will have a pleasant appearance, free of oil or floating substances, an absence of toxic substances or chemical wastes, and all in all close to those natural conditons unspoiled by man's carelessness and thoughtlessness.
- The principles behind the Ontario Water Resources Commission are sound, but the weak spot is the operation of these principles.

  It is felt that there should be considerably more liaison and co-operation between this body and the Ontario Municipal Board. What the first body will advise and assist in financing, the second body may not approve. There are many municipalities particularly smaller ones, that require both advice and financial assistance to enable them to obtain water supplies and proper sewage disposal set-ups.
- 31. The presence of these facilities is necessary to the good health of the people and also to enable them to be more attractive to industrial settlement. It is a statistical fact that 40% of the employment in this country is carried by small industry.
- 32. The greatest immediate need is a public which is fully cognizant of the problems of water pollution and sewage disposal. In every

municipality there are many demands on the public purse. Unless there is a very informed public the necessary expenditures for for water supplies and sewage control will not get the proper support.

- and domestic wastes. With such knowledge the degradation of water quality to a point where multiple use is jeopardized can be prevented. This will entail increased water pollution study by competent authorities and a large increase in personnel and equipment requirements. Accurate staffing of projects for the collection of basic water quality data is a problem for most water control authorities.
- 34. The principle of the riparian rights deserves greater support so that the cry of the Ancient Mariner -- "Water, water everywhere, but not a drop to drink" -- does not become the dirge for a heritage which was given to us to maintain, not to destroy.

#### 35. Bibliography

The Pollution of Boundary Waters and International Joint Commission, by

J.R. Menzies, Chief, Public Health Engineering Division, Department of National Health and Welfare, Ottawa.

The Ontario Water Resources Commission

## ONTARIO MEDICAL ASSOCIATION STATEMENT OF POLICY

- The Ontario Medical Association believes that the preservation of the basic freedoms and democratic rights of the individual is necessary to insure medical services satisfactory to the people of Ontario.
- 2. The maintenance of health by the prevention and/or treatment of disease is the primary concern of the medical profession and of fundamental importance to all citizens of Ontario.
- 3. The people of Ontario as recipients of physicians' services and the members of the medical profession as providers of physicians' services have certain rights and responsibilities which must be respected if a satisfactory medical service is to be continued.
- 4. The people of Ontario as the recipients of physicians' services

  must have the right to determine:
  - Whether or not they wish to prepay the cost of physicians' services.
  - 2) the insuring agency.
  - 3) the comprehensiveness of coverage.
- 5. The individual citizen must have the following rights and responsibilities:
  - 1) Freedom of choice of doctor.
  - Freedom of choice of hospital within the limits of safety to others.
  - Freedom of recourse to the courts in all disputes with whatever party.
  - Freedom to choose the method by which he will pay for or prepay his medical care.

- 6. The medical profession as the provider of physicians' services

  must have the right and in the public interest, the responsibility to:
  - Ensure that a high standard of medical services is maintained.
  - Have its composite opinion considered by those responsible for legislation in the health field.
  - Refuse to participate in any plan which in its opinion is not conducive to a continuing high standard of medical services.
  - 4) Evaluate the worth of its services and retain the principle of fee-for-service whenever and wherever possible.
  - 5) Maintain mediation committees to deal with complaints, from whatever source, be they medical, ethical or economic and respect the recommendations made by these committees.

# 7. The individual physician must have the right to:

- 1) Freedom of choice of location of practice.
- Freedom to accept or reject a patient except in cases of urgency or humanitarianism.
- Choose whether or not to become a participating physician in any insurance plan.
- 4) Determine his method of remuneration.
- 5) Submit any disputes with whatever party to the courts.
- 6) Treat his patients in and out of hospital within the limits of his competence as judged by his confreres without interference by laymen.

## 8. This Statement of Policy affirms:

- That the profession is willing to accept responsibility for the provision of a high standard of medical care for all, regardless of race, creed or economic status;
- 2) That the people as a whole and as individuals must accept economic responsibility for medical services; and
- 3) That the Ontario Medical Association continues to be in favour of the application of insurance principles to assist the public to meet this economic responsibility.

#### TWELVE PRINCIPLES OF SOCIAL SECURITY AND MEDICAL CARE

- Adopted by the Second General Assembly of the World Medical
  Association, 1948, reaffirmed by the Fourth General Assembly,
  1950, sixth General Assembly, 1952, and the nineth General
  Assembly in 1955. Endorsed by Council of the Ontario Medical
  Association in January, 1960.
- Whenever medical care is provided as part of social security, the following principles should govern its provisions:
  - Freedom of choice of physician by the patient. Liberty of physician to choose patient except in cases of urgency or humanitarianism.
  - No intervention of third party between physician and patient.
  - 3) Where medical service is to be submitted to control, this control should be exercised by physicians.
  - 4) Freedom of choice of hospital by patient.
  - 5) Freedom of the physician to choose the location and type of his practice.
  - No restriction of medication or mode of treatment by physician except in case of abuse.
  - Appropriate representation of the medical profession on every official body dealing with medical care.
  - 8) It is not in the public interest that physicians should be fulltime salaried servants of the government or social security bodies.
  - Remuneration of medical services ought not to depend directly on the financial condition of the insurance organization.

- 10) Any social security or insurance plan must be open to the participation of any licensed physician, and no physician should be compelled to participate if he does not wish to do so.
- 11) Compulsory health insurance plans should cover only those persons who are unable to make their own arrangements for medical care.
- 12) There shall be no exploitation of the physician, the physicians' services or the public by any person or organization.





